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ABSTRACT

This journal, published quarterly by Project SHARE, a national clearinghouse for improving the management of human services, contains 150 abstracts of documents on subjects of concern to those responsible for the planning, management, and delivery of human services. The documents abstracted in this journal are included in the Project SHARE automated database. Some of the subjects covered in the abstracts are accountability in a hospital social service department, the aged deaf, management of human service organizations, public and private sector partnerships to meet human service needs, burnout, child welfare, community organizations, contracting human services to the private sector, the elderly blind, budgeting, program evaluation, funding programs, health planning, youth employment, handicapped workers, teenage pregnancy and parenthood, vocational education for the disabled, and intergovernmental cooperation. The journal is divided into four parts: the abstracts, arranged in alphabetical order by title; a list of personal and corporate authors; an alphabetical list of documents; and a subject index that lists abstracts by specific subject categories. The subject index includes cross references between conceptually related index terms and cross references from synonyms to the preferred terms. Information on how to order documents and how to submit documents also is included in the journal. (KC)

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# Journal of Human Services Abstracts

VOLUME 8 NUMBER 1 January 1983


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**Journal of Human Services Abstracts**

Project SHARE
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PROJECT SHARE

**A National Clearinghouse for Improving the Management of Human Services**

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# Preface

## About This Journal

The *Journal of Human Services Abstracts* is published quarterly by Project SHARE, a National Clearinghouse for Improving the Management of Human Services. Project SHARE acquires, evaluates, stores, and makes available a broad range of documentation on subjects of concern to those responsible for the planning, management, and delivery of human services. Project SHARE is operated for the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, by Aspen Systems Corporation.

Each *Journal* announces 150 of the documents included in the Project SHARE automated data base. Additional documents acquired by SHARE are published in bibliographies on selected topics. The documents announced in SHARE's publications are restricted to those documents actually acquired by Project SHARE and are not meant to provide comprehensive coverage of the field.

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**Federal funds for regional human services**
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As can be seen, one document is relevant to at least two of the subject categories — abstract number 48.

(Sequential abstract no.)

**48** *Funding Problems in Human Services: A Local Government Perspective.*
Mary Kelly-Rader
1982, 26p

(Order number)

**SHR-0009712** Published in Jnl. of Health and Human Resources Administration v4 n4 p487- 512 Spring 1982.



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In the example we see that abstract 48, entitled *Funding Problems in Human Services: A Local Government Perspective,* was written by Mary Kelly-Rader, that the report was published in 1982 in the *Journal of Health and Human Resources Administration,* and that it is 26 pages long. If the document were available from Project SHARE, NTIS, or a private publisher, the statement would say "Project SHARE" or give another source and the address. The actual abstract of the document would immediately follow these citation data.

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# Abstracts

**1** *Accountability, Evaluation, and Quality Assurance in a Hospital Social Service Department.*
Robert M. Spano and Sander H. Lund
1980, 6p
**SHR-0009826** Pub. in Quality Review Bulletin v6 n10 p14-19 Oct 80.

This article describes the evaluation techniques used by the University of Minnesota Hospital Social Service Department, which employs 27 full-time social workers and 1 case aide to provide a range of services to the hospital's patients and their families (15,037 cases in 1979). The evaluation is based on an accountability structure composed of four tools: management by objectives (MBO), a management information system (MIS), a standard problem list, and service standards. The coordination of these facets enables staff to obtain information about their own performance, provides the department's director with an overview of the services as well as their individual providers, and supplies the hospital administration with insight into departmental operations. In addition, the accountability structure also accommodates outcome-oriented evaluation and staff performance appraisal, both in the process of being integrated into the system. Specifically, MBO enables departmental goals to be set, evaluated annually, and revised if necessary. The time-oriented, transaction-based MIS enables evaluation of the quantity and type of staff activities as related to five principal departmental functions. The standard problem list provides a uniform terminology and common data base for the hospital's Problem Oriented Medical Records system and also serves as the focus for process evaluation of social service intervention. The department service standards, reflected in the criteria for care, assist in assessing activities directed toward solving patient problems. The fifth component is a goal-oriented strategy to assess individual outcome goals for each social work problem identified in a patient's record. Five references are given.

**2** *Aged Deaf: Integration of a Disabled Group Into an Agency Serving Elderly People.*
Gaylene Becker and Gay Nadler
Hoffman-LaRoche, Inc., Nutley, NJ.
San Francisco Foundation, CA.
United Way of America, Alexandria, VA.
1980, 8p
**SHR-0009665** Pub. in The Gerontologist v20 n2 p214-221 1980.

This paper describes the process of integrating elderly deaf people into an urban multipurpose senior center. The San Francisco Senior Center (California) considered two major factors in its plans to integrate the prelingually deaf aged into its program: the disability itself and the cultural differences of the tightly-knit deaf community. The center began by deciding to sponsor a series of three workshops for the elderly deaf in 1974. Although 85 persons came to the initial meetings and expressed interest in further participation, no one returned to the second session. When the center hired a person from the deaf community as program coordinator, attendance increased considerably. The educational process was imperative in integrating deaf people into the center. The program coordinator educated hearing staff and clients, and sign language classes were started. The social worker and other staff acquainted deaf members with available social services and the concept of confidentiality. A staff member also coordinated sign language interpreting services. The deaf program coordinator instituted



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a regular weekly social gathering for deaf members that gave them a sense of identity and group support as well as exposure to other center activities. The program overlooked the importance of driving among the deaf, and parking difficulties hindered participation. Deaf members gradually have used more center services, such as the hot meal program, card games, and trips. Hearing clients and staff have gained a new sensitivity to the problems of deaf people, while deaf members benefit from social contacts with hearing and nonhearing members and improved access to social services. A total of 16 references are included.

**3** *Agency Training Programs on the Black Family: Methods, Issues, and Principles.*

Richard L. Jones
Center for Human Services, Cleveland, OH.

1 Mar 81, 22p
**SHR-0009760** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

In-service training or cultural sensitivity programs are needed because many human service practitioners have a limited knowledge and understanding of black culture that results in inaccurate and incomplete assessments of black clients. A successful sensitivity program requires support and continuous input from the board of trustees and the agency's central administration. Staff must be included in the planning process and clear objectives set. The program can be conducted by an outside consultant and should include information on black culture and institutional behavior influencing black families. Human service practitioners must realize that social problems faced by blacks result from their interaction with outside forces, such as the economic system. Cultural programs should begin with a consideration of black African heritage. Cultural forms characteristic of the black community are extended family relationships, cooperative family roles, a strong black church, and values emphasizing togetherness. Either a teacher-centered approach or the experiential method can be used in these programs; researchers disagree over which is best. When using a small group, trainers or group leaders should be carefully selected and the groups kept small. Moreover, program staff should establish a systematic method for collecting, sorting, and responding to staff concerns likely to arise during the sessions, such as concern over the few black professionals serving the black community. Reference notes are appended. *Revised.*

**4** *Aging Population Research: Suggestions for a Model Data System for Service Planning.*

Robert A. Harootyan
Administration on Aging, Washington, DC.

1982, 6p
**SHR-0009736** Pub. in The Gerontologist v 22 n2 p164-169 Apr 1982.

This article discusses the significance of recent studies on the migration patterns of the elderly and what they tell us about the trends and consequences of population redistribution among older Americans. Limitations imposed on the researchers are also addressed, especially concerning the lack of appropriate data for smaller geographic areas. Yet, it is at the county or multicounty level that basic service delivery planning and evaluations must occur. These geopolitical units are the heart of the national service network for the aged, as embodied in the older Americans Act of 1965. All area agencies on aging must have access to better information about the older population in their planning and service areas. To respond to these information needs, a model for a statewide population data system is presented, which derives from a California elderly needs assessment and data collection study. The model components are a computerized statewide

demographic data base made up of client-based information from various State agencies providing benefits and services to the elderly. A second component involves field interview surveys to assess the status and needs of the older population through using a comprehensive needs assessment questionnaire. The system's third component comprises a set of seven data sources that range from key informant and area agency on aging advisory council input to secondary data from census tabulations and local area surveys. Tabular data and 30 references are given.

**5** *Applicability of Assessment Center Concepts and Techniques for Managerial Selection and Development in Human Service Organizations.*
Gail W. McGee and Richard T. Crow
1982, 8p
**SHR-0009692** Pub. in Administration in Social Work v6 n1 p11-18 Spring 1982.

The assessment center offers numerous advantages over other methods in developing critically needed managerial competence in human service organizations. The assessment center provides one or more simulation exercises designed to elicit predetermined behaviors. The assessment center, by definition, is geared to fit the specific organization in which it is used. It accommodates the need for keeping appraisal and training behaviorally based. Emphasis is placed on observing actual behaviors while assiduously avoiding vague attitude or feeling judgments about participants. Assessment center standards mandate that all observers are trained before they assess anyone. Finally, the assessment center is an excellent vehicle for evaluating managerial potential by giving feedback to employees, thus facilitating self-appraisal early in an employee's career. A total of 16 references are included.

**6** *Assessment of a Group Intervention Model for Facilitating Movement of Needy Aged Into Unsubsidized Employment.*
Dan W. Edwards
1980, 9p
**SHR-0009705** Pub. in Jnl. of Gerontological Social Work v4 n2 p65-73 Winter 1981.

The Senior Community Employment Program, a federally subsidized employment and job training program for needy older workers, is attempting to move some enrollees through the program into unsubsidized employment by instituting a group intervention model to motivate workers seeking employment. The intervention involves social group work principles and is designed to enhance enrollees' self-esteem and self-confidence by didactic teaching through role playing and discussion. A comparison of 11 enrollees participating in the intervention with 11 who did not reveals that group intervention was effective in altering behavior. However, statistical analysis failed to indicate any significant attitude changes among each group with respect to anomie and a sense of powerlessness. This finding may not be significant given the small sample size and other study limitations. Overall, work clearly gives meaning, purpose, and direction to aged adults' lives and is as significant in their lives as religion. Tables present study results, and 10 references are included. Author abstract modified.

**7** *Block Grants and State Discretion: A Study of the Implementation of the Partnership for Health Act in Three States.*
George D. Greenberg
National Center for Health Services Research, Hyattsville, MD.
1981, 29p
**SHR-0009752** Pub. in Policy Sciences v13 n2 p153-181 Apr 81.

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This study examines the way in which decisionmakers in Michigan, Pennsylvania, and Alabama allocated health block grant funds following the consolidation of eight categorical health programs into a single block grant. The research focused on the reasons why the three States made different decisions regarding the allocations of these funds and the political, administrative, and bureaucratic factors responsible for these differences. The block grant was created in 1966 when the formula grant which supported general health department activities was combined with eight other State formula grants to form a block grant for community health services. The general goal of the 314(d) block grant was to encourage program innovation and shifts by States away from previous funding patterns. The research revealed that certain factors were at work in all States. For example, all the States had incentives to concentrate the reported use of Federal funds to simplify Federal audits. However, circumstances unique to each State resulted in varying expenditure patterns. Factors unique to each State included budget processes, accounting and financing patterns, and variations in the relationships between State health departments and county health departments. Findings indicated that more volatile changes in grant allocations will result from grant consolidations in policy areas which do not address basic service needs. In addition, the decisionmaking process regarding block grant funds is controlled by a small group of professionals who determine allocations autonomously with relatively little input from interest groups or other actors within State government. However, the choices in each State are severely limited by external political and administrative factors. Notes, tables, and detailed findings for each State are included. Author abstract modified.

8 *Board and Care: An Old Problem, A New Resource for Long Term Care.*
Carolyn Harmon
Center for the Study of Social Policy, Washington, DC.
Administration on Aging, Washington, DC.
National Conference on Social Welfare, Washington, DC.
30 Jun 82, 50p
**SHR-0009657** Available from National Conference on Social Welfare, 1730 M Street NW, Washington, DC 20036.

This report discusses the enforcement of standards for board and care homes serving the elderly and disabled and examines ways to develop these facilities as a long-term care resource. Board and care is defined generally as provision of room and board and some degree of personal care or supervision of residents in a facility operated by a nonrelative. An overview of board and care covers the numbers and characteristics of such facilities, who the residents are, and how they are financed, regulated, and administered. The principal problems in board and care are unsafe and unsanitary conditions and exploitation of residents by unscrupulous operators because of inadequate regulation and no clear professional standards. Federal involvement in board and care regulation is described, along with creative strategies adopted by some States to improve enforcement of standards. Other States have begun to develop formal bed and board care programs. Elements common to these efforts are identified, such as restricting funds to clients who are determined to need bed and board care, formal needs assessment, ongoing case management, linkages to community services, and provider recruitment and training. Examples of programs implemented in Pennsylvania, Florida, Michigan, and Oregon are provided. The report concludes with a discussion of two basic approaches – market or programmatic – which States may consider in deciding how to proceed with board and care. Tables and 22 footnotes are included.

9 *Building Networks in Urban Settings: An Approach to Delinquency Prevention.*
Scott A. Bass and Fred Mandell
Centre Research Associates, Inc., Newton, MA.

Law Enforcement Assistance Administration, Washington, DC.
1982, 6p
**SHR-0009714** Pub. in New England Jnl. of Human Services v2 n3 p20-25 Summer 1982.

The paper describes the Milltown Juvenile Delinquency Prevention Program, which was based on the concept that institutions can be restructured to better serve the diverse needs of troubled individuals, while at the same time providing them with support, sensitivity, and an opportunity to readjust to society's expectations. The program has a direct service component for court-acquainted youth at the local junior high school consisting of specially trained bilingual staff and counselors, as well as program and curriculum specialists, and offering summer wilderness experiences, vocational placements, and special activities building new relationships for delinquent youths. By analyzing case histories of juveniles in trouble, the program found that institutional responses to youths at critical points in their lives had had a significant impact on their direction in life. It created a communications network to capture and empower existing informal associations among individuals affiliated with formal youth-serving agencies to enrich service delivery at little or no additional cost. Thus, by restructuring youth-serving institutions, the project sought to create more effective relationships between youths and groups of service providers. Problems in convening and maintaining the network are discussed. Diagrams and nine notes are included.

**10** *Building Public/Private Sector Partnerships to Meet Human Needs: Something Old and Something New.*
Alex Pattakos
1982, 21p
**SHR-0009711** Pub. in Jnl. of Health and Human Resources Administration v4 n4 p513-533 Spring 1982.

Drawing upon the results of a statewide demonstration project in Illinois, the purpose of which was to develop strategies to enhance interagency coordination of manpower and related services, this article addresses the elements of the public/private interface in meeting human service needs. Project SCOPE (Services Coordination of Programs for Employment) was operated by the Center for Governmental Studies at Northern Illinois University. The project was piloted in three significant Illinois labor market areas: East St. Louis, Kankakee, and Rockford. Primary research activities included compilation and dissemination of a comprehensive resource directory outlining available services and program requirements in each region; assessment of the level of interagency activity in each region; analysis of each region in terms of exogenous factors that may influence coordination activities, including relevant economic and labor market characteristics; and development of a blueprint or guidebook for incremental interagency coordination improvement. Project findings indicate that the rhetoric surrounding the notion of public-private sector partnerships is insufficient to translate the concept into action. The development of intersectoral relationships will have to be based upon carefully formulated and implemented strategies. Detailed findings, tables, 6 notes, and 19 references are provided.

**11** *Burnout and Self-Reliance.*
Interact, Virginia Beach, VA.
1982, 7p
**SHR-0009794** Pub. in Public Welfare v40 n3 p29-35 Summer 1982.

The staff of Interact, a 24-hour crisis intervention and intake information referral service in Virginia Beach, Va., developed a method to combat staff burnout. The staff conducted a 10-week project of sensitivity training during regular staff meetings, resulting in warmer and more supportive staff meetings in which participants discuss problems and develop constructive resolutions. The agency developed a participa-

tory management approach that allows internal supervisory functions to be achieved through a group process. Stress is taken off the supervisor and concurrently, the staff are more informed about all factors immediately or potentially affecting Interact, since all memos, bulletins, and other pieces of "intelligence" are shared with staff. Interact workers are in charge of their own work schedule rather than being placed on a regular, fixed shift, which helps prevent fatigue. When on duty, two workers act as a team in responding to nonroutine telephone calls and other tasks requiring their presence at the site of a crisis. They also alternate telephone duty every 2 hours. Other elements of Interact's approach are peer supervision and detached concern. By strategically leaving the problem with the client for as long as is reasonably safe, the staff keep the client motivated to solve the problem and prevent worker burnout.

**12** *Can Organizing Tenants Improve Housing.*
John D. Morrison
Jun 81, 15p
**SHR-0009747** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

A Brooklyn, N.Y., community development project responded to deteriorating conditions in apartment buildings and a change of residents from largely white to mostly black by organizing tenants, working with them to secure code compliance, and working with landlords to resolve problems. The program's effectiveness was evaluated in organizing tenants, securing needed physical changes, and stabilizing the buildings racially and socially. Indicators studied for each building in the program included tenant complaints, tenant association meeting attendance, building size, physical condition, type of project worker, and change in tenant attitudes. The tenant organizations slowed physical decline and improved conditions, with these efforts mainly financed from current rent rolls. Medium-sized buildings in fair condition had the greatest physical improvement and success in tenant organization. Substantial differences between small buildings and other sizes suggested that they require different organizing approaches. At an average per apartment unit cost of $9.79, the project was at least as effective as other alternative housing programs although it did not improve the building's racial stabilization. Three references are provided. *Presented at 108th Annual Forum, NCSW, June 1981.*

**13** *Case Management in Long-Term Care Programs.*
Donald F. Simpson
Center for the Study of Social Policy, Washington, DC.
Administration on Aging, Washington, DC.
National Conference on Social Welfare, Washington, DC.
Mar 82, 77p
**SHR-0009656** Available from National Conference on Social Welfare, 1730 M Street NW, Washington, DC 20036.

This report traces the development of case management techniques in human service programs and then discusses current case management models. Although case management was initiated to improve agency responses to individual needs and to deploy resources effectively, the case manager is viewed increasingly as a major controller of costs. Some definitions of the case manager function focus on service coordination, while others include diagnosis, therapy, education, and advocacy. Similarities and differences among approaches to the case management model are examined in terms of projects undertaken in 12 States. Among the programs considered are Connecticut's Triage, Massachusetts' Home Care Program, California's Multipurpose Senior Citizens Project, Illinois' Community Care Program, and New York's Nursing Home Without Walls. The report concludes that the team approach in case man-

agement has encouraged integration of community-based and institutional long-term care services, with long-term care programs assuming greater responsibility for helping clients with housing, income maintenance, and financial planning. In the drive for effective cost controls, case managers have been asked to strengthen family and informal support systems. Evaluation reports from demonstration projects have shown that the demand for noninstitutional long-term care could be controlled and that alternatives to institutionalization using the case manager as the focal point for service provision and cost control provided better or comparable long-term care at a lower cost. Finally, the paper explores training as well as organizational and financing reforms that are needed to support the growing role of the case manager. A total of 45 reference notes are included.

**14** *Case Management With the Frail Elderly: A Training Manual. Volume 1.*
Jack Stumpf
Senior Care Action Network, Long Beach, CA.
Los Angeles County Dept. of Senior Citizens Affairs/Area Agency on Aging, CA.
California State Univ., Long Beach. School of Social Work.
Family Service of Long Beach, CA.
Long Beach Information, Referral and Assistance, CA.
30 Jun 82, 178p
**SHR-0009805** Available from Senior Care Action Network, 1150 East Fourth Street, Long Beach, CA 90802.

Based on the Case Management Model Project conducted by the Senior Care Action Network (SCAN) of Long Beach, Calif., this training manual discusses case management with the frail elderly. This approach develops a network of services on a contractual and continual basis and after assessing the client, identifies an individualized set of formal resources that are needed to maintain the client's most independent level of living. The four eligibility criteria for SCAN's Case Management Model Project are the physically frail, the emotionally vulnerable, the medically needy, and the at-risk of institutionalization. Case management saves money by providing help before a person becomes chronically dependent. However, before any case management program can be implemented, a coordinated, cooperative approach to meeting the frail elderly's multiple needs must be accepted by the community, and the case management agency itself must be willing to change its procedures as needed. The agency must decide on the nature of collaboration with other agencies and set up interorganizational arrangements. The manual discusses the training of agency board members, case managers, case management supervisors, and community resource coordinators. Six case management vignettes from the SCAN files, figures, notes, models of forms used in case management, and 21 annotated references are provided. *Revision of report dated June 30, 1981. See also volume 2, SHR-0009806.*

**15** *Case Management With the Frail Elderly: A Training Manual. Volume 2: A Step by Step Analysis and Instructional Guide on the Practice of Case Management.*
Jack Stumpf and Norman Davidson
Senior Care Action Network, Long Beach, CA.
Los Angeles County Dept. of Senior Citizens Affairs/Area Agency on Aging, CA.
Family Service of Long Beach, CA.
Visiting Nurse Service of Long Beach, CA.
Long Beach Information, Referral and Assistance, CA.
Dec 81, 153p
**SHR-0009806** Available from Senior Care Action Network, 1150 East Fourth Street, Long Beach, CA 90802.

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Based on the Case Management Model Project conducted by the Senior Care Action Network (SCAN) of Long Beach, Calif., this "how-to" guide for practitioners presents a step-by-step analysis of case management. It discusses each component of case management in terms of function, principles, and techniques. These components include client-finding activities (case finding), developing resources and a general network, confirming admissions, assessing the frail elderly and his or her situation, and care planning with the frail elderly. Other components are implementing the care plan and mobilizing networks, monitoring the delivered services, evaluating the impact of services on the client, including positive and negative effects, and closing the case. The forms used in case management are integrated with the text. Case illustrations, notes, and 14 annotated references are included. *See also volume 1, SHR-0009805.*

16 *Changing Roles in Serving the Underserved: Public and Private Responsibilities and Interests. Proceedings From a Symposium, October 11-13, 1981, Leesburg, Virginia.*
American Health Planning Association, Washington, DC.
Robert Wood Johnson Foundation, Princeton, NJ.
National Association of Community Health Centers, Inc., Washington, DC.
Oct 81, 164p
**SHR-0009652** Available from American Health Planning Association, 1601 Connecticut Avenue NW, Suite 700, Washington, DC 20009.

This report contains the texts of six papers commissioned for a symposium on the changing role of government in the area of health services delivery to the underserved, along with summaries of conference discussions. The general issues concerned the cumulative effects of congressional budgetary cuts in Medicaid and in block grant programs, as well as the shift of responsibilities from the Federal to State governments. The first speech assessed the new political directions in terms of impact on primary care. Next, public and private financing of primary care for the medically underserved was examined. A third presentation described hospital initiatives in response to reductions in Medicaid funding for ambulatory care programs, and a fourth reported on physician responses to the changing Federal policy on health care for the underserved. The States' dilemma regarding this issue was illustrated by a report on Wisconsin's efforts to develop a new health policy. The final presentation assessed impacts of the new Federal health policy on the future of community health centers and primary care programs. Participant discussions were based on the assumption that significant progress had been made in the past 15 years to increase access for the poor and underserved; that there will be even fewer resources in 1982 and after for services to this group; that cutbacks will hurt all programs, even those most effective in providing care for the underserved; and that prospects for State and local governments and the private sector to fill the gaps created by Federal cutbacks are uncertain. Tabular data and references are given with individual papers; a 31-item bibliography is provided. Appendices provide the program agenda, discussion guide, a chart of influences on care for the underserved, and background information on symposium speakers.

17 *Characteristics of Staff in a Community-Based System Serving the Long Term Mentally Ill.*
Nancy M. Kant
New York State Office of Mental Health, Albany. Community Support Systems.
National Inst. of Mental Health, Rockville, MD.
1981, 36p
**SHR-0009697** Available from New York State Office of Mental Health, 44 Holland Avenue, Albany, NY 12229.

This paper describes the characteristics of staff directly serving mentally ill persons through an integrated, community-based system in Schenectady, N.Y. Initiated in 1978, community care has been cost-effective and the county has remained one of the lowest users of inpatient care in the State. This study selected 25 human service agencies who reported consistent service utilization by clients aged 18 years or older with an emotional disability that was expected to persist over a long period of time. Questionnaires were administered to staff in two groups: 11 mental health agencies and 14 other human service agencies who served the long-term mentally disabled. The overall response rate was 62 percent, or 130 participants out of 209. The results indicated that all direct service staff were well-educated, were employed full time, and had worked in their present jobs for 3 to 4 years. Although job titles suggested diverse backgrounds, there was a surprising amount of similarity in services provided and the skills identified as important in delivering these services. A high percentage of staff in the mental health sector had both administrative and direct service responsibilities, and their working hours varied more than those of the other group. Both ranked crisis counseling as the most frequently provided service, followed by regularly scheduled counseling, and relied on informal methods for referrals. A total of 14 references, the survey instruments, and a list of participating agencies are appended.

**18** *Child Abuse: A Rural Case Study.*
Rosemarie B. Bogal
1981, 7p
**SHR-0009790** Pub. in Human Services in the Rural Environment v6 n3/4 p24-30 Summer/Fall 1981.

This article examines current approaches to the treatment of child abuse, using a model that includes both parents and children. A Parents Anonymous (PA) chapter in a rural community in the south central United States, which had been in existence for about 3 years, formed a children's group. The children's group provided child care while the parents were meeting, but also actively involved the children in the process of family behavioral change. Students from a local university were selected as volunteers to work with the children under the supervision of a professional. While the children had different reactions to the group experience, they generally looked forward to the meetings. Several of the parents confided that they continued to attend PA because of their children's insistence. In the summer, when there was no children's group, participation in PA dropped dramatically, testifying to its necessity. The PA sponsors and the children's group sponsor held weekly coordinating meetings to maintain continuity between the two groups. Essentially, while the two groups met separately, they had a common goal: the definition of "acceptable behavior" for both parent and child and the promotion of such change. Problems encountered in establishing the children's group included finding a suitable location for meetings and recruiting a large number of volunteers. Four notes, 1 figure, 1 photograph, and 12 references are provided.

**19** *Child Abuse Policies and Procedures: The Experience at St. Mary Medical Center.*
Louise Cunningham
1980, 5p
**SHR-0009823** Pub. in Quality Review Bulletin v6 n9 p27-31 Sep 80.

The experience of St. Mary Medical Center, in Gary, Ind., in dealing with abused children and abusing parents is discussed to illustrate an interdisciplinary approach. Since 1977, between 65 and 104 cases of child abuse and neglect have been reported yearly at St. Mary Medical Center. The policy for dealing with suspected cases at the center's two facilities complies with Indiana State law. Suspected child abuse or neglect must be reported immediately by

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telephone to the Protective Services Division of the Lake County Department of Public Welfare, with a written report following within 24 hours. The reporting staff member must also inform the child's parents of these actions and follow other legal procedures in certain situations. At St. Mary Medical Center, nurses, physicians, and hospital social workers who deal with abused children often perform multiple tasks. They must make the initial identification of suspected abuse or neglect, report the case, provide treatment, document their activities, and remain supportive to the parents. Staff members, however, are not always well prepared to follow the required team approach. Informal education among staff to enhance their understanding of each other's perspectives and of the parents, staff input in developing policies and procedures, and multidisciplinary inservice sessions are all helpful in successfully implementing hospital policies and procedures. General guidelines for hospital management of suspected child abuse and neglect cases and nine references are included.

**20** *Child Advocacy: An Outreach Approach to Rural Children.*
Bonnie C. Bedics and Glen E. Goltermann
1981, 5p
**SHR-0009791** Pub. in Human Services in the Rural Environment v6 n3/4 p45-49 Summer/Fall 1981.

Based on the special problems human service workers encounter in rural areas, the Outreach Advocacy Intervention Model is recommended as an aid for planning and executing a change in a service delivery system for children and their families. Distance, limited resources, varying community boundaries, and myths distinguish rural families from their urban counterparts. Advocacy for children in rural areas should include planned change involving cooperative efforts of citizen groups, governing bodies, and social agencies from the region. The model indicates a nine-step diagnosis procedure, beginning with a clear definition of the service gap and the population it affects. The model includes the following steps: identify gaps in the service delivery system; check to see it there is a policy or law affecting service delivery; establish the etiology of the gap in service delivery by level, whether it is on the national, State, community, or family level; ascertain the level of interaction; and discover which interest group could be effective in any planned action. In addition, determine the degree of interest by this agency, group or contact person; work out an intervention strategy using the vested interest of the agency, group, or contact person; decide on a strategy; and develop a prognosis for success. Four references and one figure are supplied.

**21** *Child Protective Services: Standards for Services Delivery.*
Isadora Hare
May 80, 15p
**SHR-0009740** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

This paper contends that protective service workers should be social workers. The Federal Government has encouraged States to adopt professional guidelines in this area, and the National Association of Social Workers has established a task force to develop standards for social work practice in child protection. The standards state that the ethics, values, knowledge, and skills of the social work profession best prepare child protective services staff for effective intervention. The standards also establish professional expectations so that social workers can monitor, evaluate, and improve their own practices and can be measured in their work performance by administrators. Six standards relate to the attainment of competence for all social workers addressing the profession's generic component, five address the administrative arrangements necessary for management of a professional staff, and five

others concern supervisory roles to ensure that clients receive prompt and competent assistance from the child protection staff. The standards for child protection staff document the practice expectation of social workers in direct intervention, written recordkeeping and reporting, and all aspects of the work aimed at enabling children to remain with their parents or at planning permanent alternatives. A total of 24 footnotes are included. *Presented at the National Conference on Social Welfare, Annual Meeting, Cleveland, Ohio, May 1980.*

**22** *Child Welfare Practice in Small Communities.*
Bill Horner and John O'Neill
1981, 8p
**SHR-0009788** Pub. in Human Services in the Rural Environment v6 n3/4 p16-23 Summer/Fall 1981.

While urban child welfare workers just recently have started using the case management approach in dealing with clients, rural child welfare workers have used it for many years due to contextual factors impinging on rural practice. These factors include geography, with the service area covering a large region, lack of formal resources, easy accessibility of local community resources, lack of control over external forces, and the social worker's high visibility in the community. Rural social workers use parenting adults as primary decisionmakers, assess social, economic, and physical factors affecting families, and often link nonprofessional helping systems to families. These characteristics are often in sharp contrast to urban social workers. Rural social workers are forced to perform multiple roles rather than specialize in intensive one-to-one therapeutic relationships. Their activities include establishing a child abuse council, developing a service network among various agencies and groups, completing a community-needs assessment, developing volunteer groups, and working out a team approach to service delivery. Two notes and 22 references are provided. *Derived from a paper presented at the Sixth National Institute on Social Work in Rural Areas held in Beaufort, South Carolina, in July, 1981.*

**23** *Community-Based Organizations and CETA.*
Lawrence N. Bailis
1982, 5p
**SHR-0009793** Pub. in Jnl. of Community Action v1 n3 p21-25 1982.

This article analyzes the relationship between the Comprehensive Employment and Training Act (CETA) and community-based organizations (CBO's), which were heavily funded by CETA, served its goals in finding training and employing disadvantaged Americans, and must now reorient themselves in the wake of severe cutbacks in Federal funds. It contends that major changes in the structure and functioning of employment and training programs will be required. In the near future, government bodies will be deciding what role, if any, CBO's should play in the planning and administration of skills training programs for the disadvantaged. In addition to political factors, empirically based evaluations of the potential and limitations of community groups should be considered in the decisionmaking process. To further such planning at both the Federal and local levels, assessments of CBO's 8-year involvement with CETA should highlight the CBO's role as advocates for the client community, as links between the community and the more mainstream training institutions, and as direct deliverers of classroom training services. In addition, the issue of the management performance of community groups must be addressed and the widespread belief countered that such groups cannot be relied upon to carry out their employment and training responsibilities in a "businesslike" way (i.e., with adequate recordkeeping and accounting safeguards). Three references are given.

**24** *Community Care of the Mentally Ill: The California Experience.*
Harold E. Mavrite
Jun 81, 38p

**SHR-0009746** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

Deinstitutionalization of the mentally ill in California has significantly reduced the State's hospital population, but the community care system has not improved the functioning or quality of life of most psychotic patients released from institutions. At the instigation of a legislative committee, a coalition of mental health providers and consumers developed a comprehensive, locally administered model for mental health services. The model recommends that counties assure their residents access to the following services: 24-hour intensive care, short-term crisis residential care, 24-hour transition care, long-term rehabilitative care, supervised out-of-home placement, crisis intervention, acute day treatment, outpatient services, case management, community support services, advocacy, and community services to the justice system. The paper describes the model's individual service components, prescribes necessary amounts of service for a standard population base of 100,000, and summarizes special standards formulated for children and youth services. The model's cost effectiveness and proposed revisions in civil commitment laws also are discussed. Seven references are included.

**25** *Community Empowerment Through the Needs Assessment Process.*
Michael Hibbard and Duncan Lindsey
Jun 81, 11p
**SHR-0009744** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

This paper describes and analyzes the experiences of the Economic Opportunity Commission (EOC) of San Luis Obispo County, Calif., with community empowerment. Community Action Agencies (CAA's) were mandated to provide opportunities for citizen participation in their decisionmaking, but the nature of this participation has changed in response to politics. Originally service providers, CAA's were pushed into community development by the Carter administration. The EOC served a rural conservative area with traditional programming in its planning efforts and the community development mandate. An outside consultant and the planning staff determined that participation could be viewed as a community development issue to promote citizen involvement in planning and instituting change. They devised a two-stage plan for implementing an interactive needs assessment based on the key informant technique. If a group of 48 informants could be developed, it would be expanded and ongoing information networks created. Informants were drawn from constituent groups – seniors, the disabled, farmworkers, single-parent families, unemployed and underemployed, and minorities – from four geographic areas. Although only 26 informants had been recruited after 9 months, the EOC decided to proceed into community development committees along geographic lines. This phase has not been completely implemented, although funding for administrative expenses and additional staff has been secured. The effort cannot be evaluated yet, but the small group of informants has provided important insights into EOC's services. Seven footnotes are included. *Presented at the 108th Annual Forum National Conference on Social Welfare, San Francisco, California, June 8, 1981.*

**26** *Community Organization Issues in Services to Deinstitutionalized Psychiatric Patients.*
Carolyn L. Peterson and Marie Weil
University of Southern California, Los Angeles. Dept. of Psychiatry and the Behavioral Sciences.
National Inst. of Mental Health, Rockville, MD.
Jun 81, 25p
**SHR-0009742** Available from National Conference on Social Welfare,

Room 911, 1730 M Street NW, Washington, DC 20036.

To improve the quality of community care facilities for deinstitutionalized psychiatric patients, the University of Southern California School of Medicine's continuing education program for mental health workers focused on mental health consultation, regulations, social role transformation of deinstitutionalized psychiatric patients, and increased resource utilization. It also tried to involve the community in program planning by creating an advisory committee and establishing relationships with groups having some citizen or political clout. Issues presented to these organizations included the importance of community care facilities in the mental health service system, mandated assessments and funding for these programs, zoning problems, referrals, and continuing education for community care administrators. These activities generated publicity for the continuing education efforts and produced liaisons with other community care organizations throughout the State. Guidelines for community organization work and recommendations regarding future activities are given. A total of 34 references are provided.

**27** *Community Representation and Empowerment in Long Term Care Institutions: The Case of the Nursing Home Patient Ombudsman.*
Abraham Monk and Lenard W. Kaye
Columbia Univ., New York.
Andrus Memorial Foundation, Washington, DC.
Jun 81, 22p
**SHR-0009762** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

To determine the extent to which community resident involvement reduces the isolation, vulnerability, and powerlessness of the frail elderly residing in nursing homes, a 1979 to 1980 survey study examined the experience of the New York City Nursing Home Patient Ombudsman Program. Structured interviews were carried out in 22 skilled nursing and health-related facilities with 61 long-term care staff, 25 volunteer ombudsmen, 24 community advisory board members, and 210 actual residents of long-stay institutions. Secondary analysis of program records and semistructured interviews with various respondents within the program's interorganizational support network supplemented these primary data sources. The study focused on the status of the program's Committees of Auspice or borough advisory boards, the quality of interorganizational relations and coalitions throughout the secondary support network, the efficacy of program efforts, the role behaviors and power acquisitional needs of community ombudsmen, and factors limiting effective community intervention. Both the patient representative and the advisory board represent the primary mechanisms through which the Ombudsmen Program has sought to increase community consciousness of issues in long-term institutional care. However, the development of interorganizational coalitions is largely the result of advisory boards' efforts and the program's salaried staff. Volunteer ombudsmen have only minimal exposure to groups both inside and outside their assigned facility. Policy recommendations include having legislation give greater recognition to the therapeutic, mediative, and advocate approaches practiced by nursing home ombudsmen and giving volunteer community ombudsmen a generalist orientation with expertise in selected problem situations. Nine references and one note are included. *Presented at the 108th Annual Forum, National Conference on Social Welfare, San Francisco, California, June 10, 1981.*

**28** *Comparative Unit Costing Research Findings for a Coordinated Human Service Transportation System.*
David J. Evak and Richard Weidenheft
United Services Agency, Wilkes-Barre, PA.

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Office of Human Development Services, Washington, DC. Transportation Initiative Office.
Pennsylvania Dept. of Public Welfare, Harrisburg.
25 Sep 81, 45p
**SHR-0009683** Available from United Services Agency, Administrative Offices, 111 North Pennsylvania Blvd., Wilkes-Barre, PA 18701.

This study reports a demonstration project comparing various methods of cost allocation within a transportation service system that delivers 200,000 one-way passenger trips per year for 11 separate public and private agencies throughout a region comprised of both rural and metropolitan areas. It undertook to define from the accounting viewpoint a practical balance (i.e., point of diminishing return) between the need for producing administratively useful accounting data (unit cost and service delivery) and the "paperwork" burden associated with the provision of human service transportation. The research considered which of several commonly used unit costing methods provides the most practical administrative routine for the allocation of transportation costs while optimizing system processing performance. Specifically examined was the effect each method had on the pattern and allocation of costs to each purchaser; on administrative processing, computer, and driver time; and on corresponding costs associated with the activities required by each method. Four separate unit costing methods were compared: one-way passenger trip; passenger miles per trip; passenger time per trip; and combination of passenger miles and time per trip. Changes in routines and procedures were related to a number of different qualities of outcome, with the one-way trip unit costing method as the baseline measure. The study found that an increase in the amount of data collected was accompanied by an increase in both errors and information processing cost. Thus, the one-way passenger trip method provides the least costly and administratively the most expedient mechanism of accounting for client/program transportation usage. Tabular data, notes, and a four-item bibliography are given. Forms and other study materials are appended. *Demonstration to simplify transportation billing and accounting requirements.*

**29** *Comparison of Job Development Strategies in Rehabilitation.*
Richard T. Roessler and Atherton Hiett
Arkansas Rehabilitation Research and Training Center, Fayetteville.
National Inst. of Handicapped Research, Washington, DC.
Aug 82, 46p
**SHR-0009778** Available from Publications Department, Arkansas Rehabilitation Research and Training Center, PO Box 1358, Hot Springs, AR 71901.

Two experimental job development investigations – one with large firms and the other with small firms – examined the effect of different types of communication and/or contact persons on job development outcomes. For all employers involved, the issue, content, structure, and source of the message were the same: it is important to increase employment opportunities for individuals with disabilities. However, the communication emphasized such concerns as the expertise and status of the source, the benefits of participating in the program, and the potential affirmative action benefits of participation to the employer. The large firms were randomly selected to receive the appeals under one of four conditions that varied in the type of followup contact (i.e., telephone interview, response form with self-addressed envelope, scheduled appointment, or tentative appointment request) requested of the receiver (personnel manager or owner/manager). Small firms were treated similarly, with the exception of the followup visit. Results of the large firm study showed that face-to-face contact with the own-

er would not necessarily result in the most positive job development outcomes. Face-to-face contact with the personnel manager, coupled with mail and phone contact with the owner/manager, appeared to have beneficial results. For large companies with personnel managers, the importance of a carefully designed appeal letter and survey remains vital. For small companies, the outcomes of the basic mail approach – appeal letter, one-page survey, and stamped self-addressed return envelope – were as effective as those of other approaches. Tables, 22 references, and sample contact forms are provided.

**30** *Composite Model for Interorganizational Strategies.*
Donald E. Maypole
1981, 15p
**SHR-0009772** Pub. in Jnl. of Sociology and Social Welfare v9 n1 p4-18 Mar 82.

This paper develops a model for determining whether cooperation, competition, or conflict is the most appropriate interorganizational strategy for achieving a particular goal. The model integrates three types of theories: general systems theory, exchange theory, and contingency theory. General systems theory regards the system as a natural whole with interdependent parts. Exchange theory views organizational relationships that involve reciprocal exchanges of tangible or intangible units which provide benefits to both parties. Contingency theory asserts that an organization's behavior depends on the internal and external factors that affect the process of goal attainment. The development of a strategy for attaining a goal begins with identifying the problem and assessing the organization's degree of power and dependence in relation to other groups or organizations in the environment. The organization's goals must then be identified. The suitability of each of the three main strategies – cooperation, competition, and conflict – should be related to the organization's goals. The choice of strategy will be based on the assessments of power and dependence in relation to other groups and on the assessment of the probability of success of a particular strategy. After the strategy is implemented, feedback should be obtained for evaluation purposes. Figures and 27 reference notes are included.

**31** *Computerized Information Management in Long-Term Care: A Case Study.*
Rick T. Zawadski and Stephen Gee
On Lok Senior Health Services, San Francisco, CA. Community Care Organization for Dependent Adults.
Administration on Aging, Washington, DC.
Health Care Financing Administration, Washington, DC.
Jul 82, 22p
**SHR-0009679** Available from On Lok Senior Health Services, 1441 Powell Street, San Francisco, CA 94133.

This study describes the development, equipment, and functions of the computerized information management system of the On Lok Community Care Organization for Dependent Adults (CCODA). The nonprofit, community-based On Lok Senior Health Services has been serving the frail elderly in San Francisco, Calif., since 1971. In 1978, On Lok implemented the CCODA to provide all necessary health and health-related services to clients who have been certified as eligible for institutional care. To support this program, it developed a computer system to meet program, policy, and research information needs. The description of this online, microcomputer-based system covers its hardware, firmware, software, and applications. Hardware is upgraded or added as On Lok's needs change or technological breakthroughs occur. Software development has created a fiscal management component, a client management component, and an ability to integrate the two. Software is regularly written or modified to

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accommodate new users and emerging information needs. The system allows On Lok to monitor continuously the two areas of greatest concern in long-term care – cost containment and quality of care. Costs of implementing a computer system are discussed, as are its benefits in efficiency, quality of information, and innovative uses of the data. The cost savings have offset development and equipment costs in 3 years, and by 1982 the service program staff rather than the research staff were demanding more investments in computer equipment. Recommendations for other human service providers interested in computerization conclude the report. Footnotes, diagrams, and sample reports are included. *Technical report no. 303.*

**32** *Contracting Out Public Services to the Private Sector.*
M. Azher Khan
Public Technology, Inc., Washington, DC. Urban Consortium for Technology Initiatives.
Department of Housing and Urban Development, Washington, DC. Office of Policy Development and Research.
1980, 29p
**SHR-0009638** Available from Public Technology, Inc., 1301 Pennsylvania Avenue NW, Washington, DC 20004, Attn: Evangeline Pappas.

This paper reviews the status of public services contracted to the private sector in the United States, assesses reasons for this trend, and offers several illustrative case studies. Highlights from recent surveys of State and local governments demonstrate the increasing use of contracted services in areas such as tax collection, airport management, municipal fleet maintenance, and social services. Cost savings is a major reason given for contracting out public services, but other justifications include restrictive procurement policies, taxpayer resistance to increased taxes, and pressing union demands. The paper identifies key factors in a decision to contract for services, emphasizing that economic comparisons must be made of in-house and private performance of a particular service. Specific items that cost estimates should consider are detailed. The procurement process is described, with attention to specification of contractual requirements, contract administration, and service evaluation. Case studies describe formation of a nonprofit corporation to provide municipal data processing in San Diego, Calif.; a fleet management contract in Gainesville, Fla.; park food services contracted to restaurants in Dade County, Fla.; and efforts in Hennepin County, Minn., to contract out social services for mentally retarded adults. The appendices contain checklists to help public managers evaluate alternative methods of service provision and five references. *Information Bulletin of the Management, Finance, and Personnel Task Force of the Urban Consortium.*

**33** *Contracting With the Private Sector.*
Patricia S. Florestano
1982, 8p
**SHR-0009693** Pub. in National Civic Review v71 n7 p350-357 Jul/Aug 1982.

Local governments' choice of providing services through contracts with the private sector should be guided by a careful consideration of legal, economic, political, and administrative issues. Basic to any discussion of contracting are legal constraints or requirements. A search of Federal, State, and local laws and of relevant labor contracts will indicate conditions under which contracting is allowed. In addition, the political beliefs of the community – particularly the traditional feelings about the governments' role and the separation of government and the private sector – should be taken into account. Characteristics of the services to be delivered are also factors. Tangible services with clearcut dimensions, new services, and services which require unique equipment or are done on an infrequent or seasonal basis are most likely to be contracted out. Of course, cost is a major



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factor, and local officials will need to assess the level of service being currently offered, the desired level of service, and the cost of providing both levels in-house before they make the decision to go to the private sector. Once the decision to contract for services is made, officials will need to prepare clear and comprehensive specifications of the job to be done and performance quality and quantity. Bidders will need to be rated and negotiated with. After contract award, officials will need to monitor performance. Some efficiency and quality measures are input-output ratios, resource utilization rates, community desire for and willingness to pay for services, and service level against specifications. References are given within the text.

**34** *Contracting With the Private Sector for Municipal Services: A Dialogue Between Practitioners.*
Paul Jay Muzychenko
International City Management Association, Washington, DC. Management Information Service.
Apr 80, 17p
**SHR-0009720** Available from International City Management Association, 1140 Connecticut Avenue, Washington, DC 20036.

The report discusses the advantages and disadvantages of contracting with the private sector and offers practical approaches and suggestions from five local government practitioners who have had experience in contracting out. Using the transcript of a session on contracting out held at the 1979 International City Management Association Annual Conference and two recent reports on contracting with the private sector, the issue presents the practitioners' views by topic area. Their oral and written remarks emphasize the problems they as practitioners have encountered and the decisions they have made. With the advantages and disadvantages introduced as a backdrop, the discussion turns to how the participants have analyzed the feasibility of contracting out in their jurisdictions or area of expertise. Several different systematic approaches in considering a change to contract service are described, from determining the level of service desired to weighing the cost of providing services in-house versus contractually. Next, the practitioners offer some procedures they have used in procuring proposals and bids and some instructive considerations in specifying the contract terms. The following section on implementing contracting out focuses on potential difficulties with existing employees and unions. The report concludes with the rundown of the central points of contract administration: training qualified in-house managers and inspectors and developing effectiveness measures to monitor the contractor's ongoing performance. Case studies and tables are included. Author abstract modified. *Management Information Service Report, v12 n4 Apr 80 (complete issue).*

**35** *Declining Public Social Service Resources: A Managerial Problem.*
Wilbur A. Finch
1982, 10p
**SHR-0009690** Pub. in Administration in Social Work v6 n1 p19-28 Spring 1982.

The paper discusses how declining resources affect the organizational context of work, problems resulting from declining resources, and essential managerial tasks in a "cutback" environment. Declining resources increase the likelihood of organizational stress, especially as allocation decisions benefit one group at the expense of others. Reduced aspirations disrupt individuals' personal motivations for working in the organization and produces a new set of managerial problems. When management emphasizes economy of resources over competency, mediocrity, employee dissatisfaction, and burnout often result. However, the moderation of unreasonable demands and the development of objective criteria that minimize long-term loss for the agency offer ways of maintaining

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the organization's unique competence in services while restoring employees' concerns with improved capability. A total of 21 references are included.

36 *Developing a 24 Hour Emergency Family Care Program Within a Home Health Agency.*
Lou Fox; Lillian Johnson and Linda Remy
San Francisco Home Health Service, CA. Emergency Family Care Program.
Jun 81, 15p
**SHR-0009741** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

This paper describes the evolution of the San Francisco Home Health Service (SFHHS) in California from a home health agency serving only the chronically ill and disabled to one serving a broader and more diverse population through the cooperation of groups and individuals interested in services for children. An advocacy group concerned with the needs of abused and neglected children requested help from SFHHS, resulting in a feasibility study of the need for in-home services for problem families and children and then a pilot program targeting these individuals. With the financial support of 11 national and local foundations, the cooperation of over 20 public and private community agencies, and hundreds of people participating in meetings, SFHHS was able to launch the Emergency Family Care Program in 1980. This communitywide effort succeeded because children's service providers believed that in-home care was needed to prevent or reduce the number of out-of-home child placements. The paper outlines program activities and illustrates a program evaluation model.

37 *Dollars and Sense: A Community Fundraising Manual for Women's Shelters and Other Non-Profit Organizations.*
Pam Miller and Marya Grambs
Western States Shelter Network, San Francisco, CA.
Levi Strauss Foundation, San Francisco, CA.
1982, 135p
**SHR-0009660** Available from Western States Shelter Network, 870 Market Street, Suite 1058, San Francisco, CA 94102.

Written from the feminist perspective, this manual details community fundraising techniques for grassroots programs or controversial issues such as rape, battery, or antinuclear efforts. The information is a product of a 20-month project to survey and test successful community fundraising methods used by shelters and other women's programs. Traditional attitudes that women often hold about money and asking for money are explored, along with exercises to help groups examine their personal feelings on the subject. Special problems that women's organizations encounter in fundraising are identified, with sample scenarios. Chapters on supportive components of fundraising cover recordkeeping procedures, mailing lists, and public relations. The manual emphasizes the importance of a newsletter and offers guidelines for producing one. Basic steps that lay the groundwork for fundraising are described, including research on other community organizations, establishing ties with other service groups, creating auxiliary support groups, and assessing the board of directors. Ideas for systematically planning for the future rather than reacting on a crisis basis are presented. Finally, several hands-on fundraising approaches are described: direct mail, membership systems, major donor solicitation, a fundraising campaign, a speakers' bureau, special events like a testimonial banquet, and planned giving. Capital fundraising drives and small enterprise development are also discussed. Samples of written materials that accompany these efforts are included.

**38** *Early Adolescence and Religion: A Status Study.*
Anita M. Farel
Center for Early Adolescence, Carrboro, NC.
Lilly Endowment, Inc., Indianapolis, IN.
1982, 45p
**SHR-0009671** Available from Center for Early Adolescence, Suite 223, Carr Mill Mall, Carrboro, NC 27510.

This report reviews the literature on adolescent development and religious attitudes and the value of traditional religious beliefs and institutions to the young adolescent. It also describes successful religious programs for young adolescents. The report is addressed to those who are interested in improving religious youth programs. Adolescents experience enormous pressure from social, psychological, and biological changes. As a result, they have an intense need to examine and test their moral attitudes and religious beliefs. Young adolescents want help in making connections between their religious beliefs and their daily lives. They turn to clergy and youth workers for help in decisionmaking and in coping with problems. Religious institutions offer an environment where spiritual, emotional, intellectual, recreational, and social needs can be met for young adolescents. Religious leaders should serve as mentors rather than as indoctrinators when young people are examining the meaning of death and developing a deeper understanding of religion. Successful religious youth programs provide a comfortable setting in which young people can explore the bases of their religious faith. Such programs also connect religious traditions with varied opportunities for self-discovery and self-definition, involve both young people and their parents, have clearly defined rules, are guided by mature adults, and permit youths to gain a sense of competence. Five successful programs are described. An annotated list of about 50 references and descriptions and addresses of 25 resource organizations are supplied.

**39** *Effectiveness Budgeting: The Limits of Budget Reform.*
James M. Harkin
1982, 15p
**SHR-0009811** Pub. in Policy Studies Review v2 n1 p112-126 Aug 82.

Effectiveness budgeting is any one of a number of budgeting techniques attempting to link activities with intended outcomes to produce desired results in the budget cycle's operation. The focus is on using information to promote agreement to assure the greatest possible return on the use of an organization's resources. Types of budgeting with effectiveness orientation are Management by Objectives, Zero-based Budgeting, and Program Planning and Budgeting Systems. Effectiveness budgeting cannot work unless those responsible for budgeting have the political will to make it work. Effectiveness budgeting is easier where the government's mission is more explicit, the standard of effective service is decided in technical terms, relevant externalities are controlled, and a single government has responsibility for revenue raising and service delivery. It also experiences greater success when service responsibility is clearly identified and the relationship between activities and outcomes is emphasized, when the national government takes responsibility for research and costs are thus reduced, and when budgetary responsibility is held by a strong chief executive. However, these factors may be difficult to achieve without compromise or qualification. Thirty-five references are included.

**40** *Elderly Blind in Nursing Homes: The Need for a Coordinated In-Service Training Policy.*
Robert J. Wineburg
1982, 11p
**SHR-0009709** Pub. in Jnl. of Gerontological Social Work v4 n3/4 p67-77 Spring/Summer 1982.

Issues surrounding the problem of delivering services to elderly blind residents in nursing homes are addressed. General public misunderstanding, blind service agencies' lack of resources, and general nursing home problems like high staff turnover rates make it difficult to establish ongoing effective training programs. Wolf (1975) found that the majority of elderly blind nursing home residents are overlooked, neglected, or treated roughly. According to Boyce (1975), the number of such residents is unknown but probably growing daily. Blindness in the elderly is often not diagnosed and is not officially listed as a major ailment, although it may be intertwined with other health problems. Inservice training on blindness for nursing home staff would be effective in countering public misunderstanding about blindness that permeates the nursing home sphere. It would also ward off complications caused by unrecognized visual problems compounding residents' other ailments and would ensure better short-term and long-term treatment for the elderly blind. Rigorously evaluated training programs could solve some of the problems involved in coordinating the blind service system and nursing home network to establish a national inservice training policy on blindness for nursing home staff. Notes and 18 references are supplied.

**41** *Emergency Assistance and Special Needs Programs in the AFDC System.*
Michael Sosin
Wisconsin Univ.-Madison. Inst. for Research on Poverty.
Office of Human Development Services, Washington, DC. Office of Research and Demonstration.
1982, 15p
**SHR-0009750** Pub. in Social Service Review v55 n2 p196-210 Jun 82.

State policy relating to emergency and special needs programs is closely bound up with policies surrounding the basic grant. States may develop public emergency assistance and special needs programs to meet both occasional unexpected financial problems and chronic needs for extra funds. These programs have increased in importance as the Aid to Families with Dependent Children (AFDC) programs moved away from individualization of assistance toward systems based on flat grants. The three specialized programs to compensate for needs that cannot be met by flat grants are AFDC-Emergency Assistance, AFDC-Special Needs, and State-funded programs. Under the emergency assistance program, States can dispense one-time grants to families threatened by destitution. Special needs money is generally distributed as part of the AFDC grant and is subject to AFDC's review of errors. Some States combine a normally flat grant with a few well-controlled expenditures labeled as special need provisions. Some States have separate programs, such as emergency energy loans and disaster programs, which are available to people other than AFDC recipients. Specialized programs are currently more common in States with high AFDC benefits and reduced commitments to a standardized calculation of income-maintenance grants. In contrast, AFDC emergency programs appear to be larger in States with low AFDC benefits and more emphasis on standardization. The Reagan administration proposal to combine emergency assistance with the emergency energy program would not change the disparities among States. Tables and 15 reference notes are given.

**42** *Empirical Study of Competition in Municipal Service Delivery.*
E. S. Savas
National Science Foundation, Washington, DC. Advanced Productivity Research and Technology Program.
1977, 8p
**SHR-0009725** Pub. in Public Administration Review v37 n6 p717-724 Nov/Dec 1977.

This article describes the Minneapolis, Minn., refuse collection system, chosen as a case study of the effects of competition between public and private local service provision. In Minneapolis, both public and private refuse collection services are operative, each serving large fractions of city households and neither decisively predominating. In addition to the municipal refuse collection, the city expanded service by contracting with a corporation of some 50 private firms and exerted considerable monitoring attention of the corporation's performance with the contract. It kept accurate inventory of the households serviced by the department and by the corporation and received citizen inquiries and complaints. From these records, four performance measures can be calculated: cost per ton, cost per household, tons collected per truck per shift, and telephone calls per year per household. The first two records measure economic performance, the third measures performance in terms of workload, and the last is a quality measure. The competitive system has resulted in increased productivity of the city agency according to all these measures, and the perceived quality of the system also appears to be improving. Although the data do not prove causality, they do indicate that competition was primarily responsible for the large observed increase in productivity. The empirical findings derived from Minneapolis should encourage officials in local governments elsewhere to adopt competition as a conscious management policy and as a strategic weapon to improve their public services. Tables, charts, and 19 footnotes are provided.

**43** *Evaluating State Level Integration of Human Services.*
Michael Frumkin; Allen Imershein; Richard Chackerian and Patricia Martin
Jun 81, 26p
**SHR-0009765** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

States are moving toward integrated human service systems, but knowledge concerning the impact of such systems is limited. Florida's Department of Health and Rehabilitative Services has been integrated longer than other States' systems. Two major descriptive studies of Florida's system have been conducted by Lynn and the National Academy of Public Administration, as well as numerous internal studies and one exploring how clients are treated within the system. However, these studies fall short of adequately evaluating the promise of integration. A methodology for studying integrated State systems can be developed. Organizational performance can be assessed by studying the daily activities and decisions within specific organizational structures. Moreover, any evaluation of integrated systems must focus on the program's ability to match client needs with organizational solutions. Thus, the clients demand for and response to services, the organization's structure, the organization's solutions and manner of delivery, etc., must be investigated. Specific client and organizational data are needed. Organizational functioning must be evaluated; two means of determining effectiveness and efficiency are a comparative versus a normative approach. The advantages and disadvantages of each approach are outlined. A chart illustrates types of data needed for the evaluation. Footnotes are presented. *Paper prepared for presentation at the National Conference on Social Welfare, San Francisco, California, June 10, 1981.*

**44** *Evaluating the Process of Nursing Care in Long Term Care Facilities.*
Ann Baldwin Mech
1979, 7p
**SHR-0009816** Pub. in Quality Review Bulletin v6 n3 p24-30 Mar 80.

An assessment of nursing care in four Maryland long-term care institutions found that patients with similar nursing care requirements received unequal quality of care. Observers used the Quality Patient Care Scale (49 of its 68 items) to

assess the quality of performance exhibited by staff nurses in the institutions, which held from 84 to 176 patients. The homes represented both urban and rural areas and proprietary and nonproprietary status. At each facility, 20 patients were selected based on age between 65 and 85, length of residence between 3 and 84 months, and a functioning level of 75 percent. The day shift was observed, and observation hours totaled 80 with 1 hour per patient at all 4 facilities. The study's finding has implications for the Medicare/Medicaid reimbursement system, which presumes equal quality statewide. Urban and nonproprietary institutions were found to provide higher quality care. Quality of care was higher when the ratio of patients requiring skilled care to patients requiring intermediate or custodial care was lower. Higher quality also correlated with larger staffs. Advantages of the process of care assessment methodology include insight into what nursing care is like from the patient's viewpoint and observation of difficulties at a time when they can be corrected (i.e., while the patient is still at the institution). Disadvantages are observer bias, numerous rating items and cues, and the amount of professional evaluator time involved. The instrument and 20 references are given.

**45** *Financial Indicators as a Measure of Nonprofit Human Service Organization Performance: The Underlying Issues.*
Ralph E. Drtina
1982, 7p
**SHR-0009715** Pub. in New England Jnl. of Human Services v2 n3 p35-41 Summer 1982.

Financial indicators offer social analysts a convenient means of determining the viability of nonprofit human service organizations (HSO's) competing for scarce resources. This article addresses three of the underlying accounting and management issues arising from the use of financial indicators in nonprofit HSO's. These are the information content of indicators, the accounting systems providing data for nonprofit HSO indicators, and the number of indicators that provide the necessary performance information. The exemplar for development of financial indicators in the public sector was the ratio analysis format long been used by business financial analysts. The enduring advantage of ratio analysis is its ability to synthesize a morass of financial information into a concise and meaningful set of comparable indicators. Four classifications of ratios based on the analyst's needs orientation appear common: profitability ratios, short-term solvency (liquidity) ratios, long-term solvency ratios, and efficiency (turnover) ratios. A trend of favorable indicators over several years implies that the nonprofit HSO has proven its ability to manage its resources in the past and may be expected to continue doing so. A financial accounting system needs a reporting focus consistent with the organization's objectives. The choice of an accounting basis (the timing of resource acquisition) is often clearly related to the reporting focus. General professional agreement has established that private nonprofit HSO's should use the accrual basis of accounting and that their reports should contain measurements of operating expenses and revenues. However, nonprofit HSO's do not appear to be using a common accounting basis. The number of indicators selected should be limited to a meaningful number, perhaps using 21 as a starting point for ratio selection. On balance, financial indicators can provide a good starting point for funding decisions and can be used to ferret out organizations that have not proven financially stable in the past. Tables and 23 notes are included.

**46** *Findings and Recommendations of the Nutrition Watch Committee.*
Evangeline Gouletas-Carey and Alan Pifer
New York State Nutrition Watch Committee, Albany.
Jun 82, 26p
**SHR-0009801** Available from Nutrition Watch Committee, The New

York State Department of Health, Tower Building, Room 2412, Empire State Plaza, Albany, NY 12237.

Hunger and malnutrition were two key issues studied by the New York State Nutrition Watch Committee. The length and severity of the economic recession, increased living costs, reductions in the Food Stamp Program and other government assistance for working poor families, and the lack of outreach to needy individuals who are eligible for these programs all are factors leading to increased hunger in New York State. Malnutrition in New York can partly be resolved by better nutrition education for children in the schools, for adults generally, and for future health professionals. The committee recommends that the State must encourage the development and implementation of a coherent and comprehensive approach to the myriad issues surrounding the objective of a healthy citizenry. The State must remove obstacles that inhibit client participation in food-aid programs, develop the capacity to respond quickly to emergency situations, and commit itself to a long-range strategy of developing nutrition education programs.

**47** *Framework for Technology Transfer and Brokering in Human Services.*
Phyllis T. Elliott
Welfare Research Inc., Albany, NY.
Office of Human Development Services, Washington, DC.
Jul 82, 31p
**SHR-0009701** Available from WRI, 10th Floor, 112 State Street, Albany, NY 12207.

This paper outlines a systematic process by which innovative tools and practices developed by one organization are adapted and implemented by a second organization with the help of a third party facilitator or broker. This technology transfer can help human service agencies meet demands for improved management and cost-effective service delivery, with Federal agencies possibly acting as the broker. The model presented in this report is based on the experiences of a 3-year Human Services Management Transfer Project funded by the Office of Human Development Services (HDS). The framework for technology transfer has four key components: conditions for transfer, levels of effort, stages of transfer, and elements of the transfer process. Conditions include key tools, actors, and organizations that must be present for successful transfer to occur. Levels of effort reflect the degrees of complexity in transferring technologies between and among human service organizations. The process for transfer is divided into four distinct stages: identification, assessment, commitment, and adaptation/implementation. Finally, the model considers several variables that influence transfers, including degree of need, a positive organizational and political climate, commitment from top administrators, realistic time frames, and adequate technical assistance. Resources for technology transfer are identified, such as the private sector, volunteers, and mutual support among human service organizations. Figures are included. Reports on the Human Services Management Project and other HDS technology transfer efforts are appended.

**48** *Funding Problems in Human Services: A Local Government Perspective.*
Mary Kelly-Rader
1982, 26p
**SHR-0009712** Pub. in Jnl. of Health and Human Resources Administration v4 n4 p487-512 Spring 1982.

In recent years, the twin factors of increased scarcity of financial resources and growing demand for services have forced funding crises upon a number of cities. Local human services budgetary shortfalls have been promoted by inflation, shrinking real revenues, restricted use of human services dollars, and State control of local government taxation. Indiana local governments have historically been unable to use

or even coordinate the largest amount of local tax dollars devoted to human services: township trustee funds (or poor relief). Moreover, local governments are subject to crises that require emergency funding and are unable to tap DHHS dollars channeled through the State. The growth in demand for human services has also burdened local governments. The failure to implement organizational change in local agencies delivering services has contributed to the lack of effectiveness in service provision. Service structures were thrown together in a haphazard way resulting in duplicative, fragmented delivery mechanisms. The Federal Government has the greatest control over human service dollars, followed by States. Local governments have little control over input into how service delivery structures are operated even though they are the primary human service activity sites. They have been unable to access Federal dollars channeled through the States and are unable financially to pay for the coordinative activities required to obtain these funds. A chart displays nine principal types of funding patterns. Eight notes and six references are also supplied.

**49** *Geriatric Day Care: The Options Reconsidered.*
Eleanor Gurewitsch
1982, 6p
**SHR-0009829** Pub. in Aging nos. 329/330 p21-26 Jul/Aug 82.

Geriatric day care facilities, similar to day hospitals in England and Switzerland, are needed to match the increasing demands of the frail elderly's health care needs. Geriatric day care can provide a viable and relatively cheap alternative to many frail elderly who otherwise would be forced into institutions. Some day hospitals are rehabilitative, while others are basically sheltered, somewhat medically oriented long-term "holding operations." Examples of various geriatric day facilities include the Rehabilitation Day Hospital of Jacobi Hospital, Bronx, N.Y.; the Day Center for the Elderly located in the Mosholu Montefiore Community Center, Bronx, N.Y.; Manchester Day Hospital, Manchester, England; and the Affoltern Day Hospital, Switzerland. Day hospitals allow the caregivers (usually family) to get relief from looking after elderly relatives, while providing the elderly person a chance to have regular social contact, needed therapy, and other medical care for less expense than in an institutionalized setting. Moreover, day hospitals allow the frail elderly to maintain as much independence as they can manage. However, private and public insurers are not inclined to support geriatric day hospitals; help is needed at both the local and national levels to make insurers more receptive and to develop other ways of providing for day hospital services. Ten references are included.

**50** *Guide to Community Health Planning.*
Jane Thomas and Thomas A. DeChant
Institute for Health Planning, Madison, WI.
Health Resources Administration, Hyattsville, MD.
Jul 82, 226p
**SHR-0009659** Available from Institute for Health Planning, 702 North Blackhawk Avenue, Madison, WI 53705.

This guide provides a model for health planning by volunteer community groups with limited resources. The model consolidates health planning ideas presented by several planning theorists over the past 10 years. The planning group first identifies the quality of life concerns and the health-related elements to be addressed. These elements are then refined and a priority health status problem is selected. Next, the problem is analyzed to determine what factors lifestyle, environment, human biology, and the medical care system can alter. Detailed methods of analysis are presented for developing specific intervention strategies through lifestyle behavior change and the medical care system. The model narrows broad community

health concerns down to manageable single issues for which intervention strategies can be designed, implemented, and evaluated. Planning and implementation activities should be based on the use of language that is understandable to the specific audience; awareness of the particular community's social, political, and cultural milieu; involvement of key community leaders in the study, planning, and action process; familiarity with the social networks where informal decisionmaking occurs; and knowledge of the educational target. Finally, planners should establish priorities and a plan of action but should also take advantage of unplanned change and opportunities, while defining issues in terms of popular perceptions and trends. Tabular data, figures, notes, and an annotated list of 15 selected readings are given. Appendices contain indicators and data sources used in health planning and a list of operational measures by six characteristics. Author abstract modified. *Volunteers in Health Planning series.*

**51** *Guidelines for Evaluating Hospital-Based Continuing Education Programs.*
William L. Holzemer and Timothy L. Bridge
1979, 6p
**SHR-0009813** Pub. in Quality Review Bulletin v5 n8 p2-7 Aug 79.

Data from evaluating hospital-based continuing education (CE) programs can be used not only to determine who should attend a program and what topics should be addressed but also to ascertain whether program objectives were met. Health care professionals have been required since the late 1960's to show evidence of participation in CE programs as a condition for relicensure, hospital staff privileges, and professional society membership. Evaluators distinguish between two types of evaluations: formative and summative. Both are relevant to CE programs, the former to improve the program and the latter to determine its overall impact. The three types of evaluation data can be labeled product, process, and context. Product data are measures of program outcomes; process data measure the quality of activities taking place during a program; and context data are measures of those aspects of the program necessary to present it most effectively. Audiences for these evaluations should be interviewed to determine what data should be gathered and presented. An evaluation plan consists of five phases: formulating goals, objectives, and questions; constructing a variable list; selecting a design; choosing assessment tools; and formulating an evaluation schedule. Evaluation can help program planners become more productive and perform better. Thirteen references are cited.

**52** *Health and Social Services for the Aged in the United States.*
Charlene Harrington and Robert J. Newcomer
California Univ., San Francisco. Aging Health Policy Center.
May 81, 63p
**SHR-0009668** Available from Aging Health Policy Center, University of California, San Francisco, CA 94143.

This paper examines the existing system for delivering long-term care to the elderly in the United States, with particular attention to the major Federal programs and to the obstacles to effective service delivery in these programs. Long-term care services for the elderly have grown rapidly, supported by both public and private funds and by the volunteer efforts of families and community agencies. The four major sources of public funds have been Medicare, Medicaid, social security services, and the Administration on Aging. These programs provide a wide range of services but are directed mainly to those who are poor. Current Federal policies have required reimbursement for high-cost institutional services and have emphasized institutional care rather than community care or in-home services. In addition, these policies

have been based on a medical model rather than on a social services approach. Many States are trying to plan a comprehensive delivery system for long-term care. Such a delivery system would ideally eliminate service gaps, coordinate administrative structure, and avoid the excessive reliance on medical and institutional services. The high costs of resolving such current problems as program fragmentation and service inequities deter the redesign of current systems, while cutbacks in funding levels may curtail programs. Cost containment strategies that do not restrict eligibility and benefits appear to be the most appropriate approaches to controlling the costs of medical care. The development of community-based and home services would reduce the overreliance and inappropriate use of costly institutional services. Programs that should be publicly funded and reimbursed include adult day health centers, home health services, and demonstration programs providing long-term care and case management services. Tables and 55 references are listed. *Working paper no. 15.*

**53** *Health Maintenance Organizations and the Elderly.*
Aileen Harper; Lewis H. Butler and Paul W. Newacheck
1979, 17p
**SHR-0009664** Pub. in Home Health Care Services Quarterly v1 n4 p81-, 97 Winter 1980.

Data gathered from 12 health maintenance organizations (HMO's) across the country provide the basis for a discussion of their role in serving the Medicare population, with attention to services provided, costs, marketing practices, and demand. Federal efforts to encourage HMO's as a cost containment strategy have not included incentives to place Medicare recipients in HMO's, and critics have argued that Medicare reimbursement policies actually impede elderly enrollment. The 12 HMO's examined in this study had relatively large Medicare populations, ranging from less than 10 percent to 35 percent, and most were located in the western States. Representatives from nine plans were interviewed about their organizations' marketing practices and long-range plans. Officials from four plans stated that their Medicare members had been lifelong members who stayed in the plan after retirement, while others were interested in this market as a means of expanding their business. All agreed that peer influence rather than aggressive marketing was the best means of attracting elderly enrollees. The HMO setting assures the Medicare member a prescribed level of health services for a prescribed premium rate, extending coverage and transferring Medicare billing from the recipient to the HMO. Some gaps in coverage exist, notably in dental care, hearing devices, and eyeglasses. A cost analysis showed that HMO Medicare hospital utilization was substantially lower than that exhibited by the fee-for-service sector. However, Medicare reimbursement policy does not permit the HMO or its elderly enrollees to benefit from lower use and thus lower costs. Incentives for and obstacles to HMO enrollment by the elderly are summarized. Footnotes, tables, and three references are included.

**54** *Health Planning in the United States.*
Institute for Health Planning, Madison, WI.
Health Resources Administration, Hyattsville, MD.
Sep 82, 24p
**SHR-0009779** Available from the Institute for Health Planning, 702 North Blackhawk Avenue, Madison, WI 53705.

With the apparently inevitable Federal retreat from support of health planning activities, the health planning system that has evolved over the last 40 years is on the verge of fundamental change. Much of the evolutionary shift since 1960 was orchestrated by Federal legislation and supporting regulations. The growth in agency size and influence has been directly related to availability of Federal funds and to



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various federally mandated linkages of planning to regulatory and resource allocation decisions. As communities search for ways to meet their health care systems' legitimate needs, they should reexamine the lessons of the early era. To this end, a review of the development of health planning in the United States discusses the relationships of health planning with certain key sectors in society, which can be expected to continue to influence health planning in the future. Among these are the business sector, the institutional sector, and the governmental sector. The discussion emphasizes that the factors which originally led to the emergence of community health planning will lead to some future successor organization carrying out similar functions. Among the possibilities are business-industry coalitions, hospital council planning activities, State government health planning, and independent community planning bodies.

**55** *Home Health Agencies in the 1980s.*
Anne-Marie Thom
1982, 20p
**SHR-0009808** Pub. in Home Health Care Services Quarterly v3 n1 p5-24 Spring 1982.

This article presents a review of issues in home health, including a discussion of current political philosophy and its impact on home care, an identification of problems and barriers in the home health field, and some approaches to resolve these difficulties. Among the issues explored are the administrative structure and financing of home health agencies; manpower considerations, with particular attention to the role of nursing; business practices, productivity, and the industry's image; and finally, the relationship between long-term and acute care. It is emphasized that home health agencies must survive and grow as bonafide health care facilities that are as legitimate as hospitals and nursing homes because they are the future in the health care field. One national voice for the industry is deemed essential. Nursing must identify its role in the home care field, particularly in home health agencies. Furthermore, every effort must be made to change society's value system from payment for short-term care only to payment for long-term care at home, so people can be kept at home when this is best for them and cost effective to the community at large. A total of 16 references are given. *Adapted from a presentation at a symposium on Nursing and Home Health Care in the 80s at Kansas City, Missouri.*

**56** *Home Health and In-Home Service Programs for the Chronically-Limited Elderly: Some Equity and Adequacy Considerations.*
Julianne S. Oktay and Howard A. Palley
1980, 24p
**SHR-0009706** Pub. in Home Health Care Services Quarterly v2 n4 p5-28 Winter 1981.

This paper examines the four major programs funding in-home services for the elderly – Medicare, Medicaid, Title XX of the Social Security Act, and Title III of the Older Americans Act – with a focus on the extent to which these programs achieve horizontal equity (providing comparable services for consumers with comparable needs among different States) and provide benefits sufficient to meet the social and physical needs of consumers within different States. Data indicate that the four Federal programs fail to relate in-home health and social service funding to the needs of the chronically ill elderly on an equitable State-by-State basis. The patchwork nature of State-by-State funding results in gross inequities in use of funds and in levels of in-home services available to the disabled elderly. Publicly supported home health and other in-home services for the chronically limited elderly in many States and regions are inadequate in that they often fail to meet the elderly's needs on an interprogram basis. Horizontal equity was not achieved under these programs – either separately, within each of the four programs on a State-by-State basis,

or on an interprogram State-by-State basis. Thus, a community-based system of health and social service supports is needed to enable many of the chronically ill elderly to maintain a position in the community in close proximity to caring relatives and friends. This family-oriented policy should be established by the Federal Government based on systematically developed norms. Tables, graphs, and 19 notes are supplied.

**57** *Housing Community Misfits: The Promise of Community-Based Residences.*
Kathleen A. Raffo and Ralph Brody
Federation for Community Planning, Cleveland, OH.
18 Apr 80, 25p
**SHR-0009745** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

This paper describes Cleveland's Community Residence Project (CRP), which offers potential community-based residence (CBR) organizations overall planning in meeting resistance in the neighborhood, zoning, State legislation, and legal remedies. Although deinstitutionalization policies have removed many persons from institutions, they have not provided adequate community care for these social misfits – the mentally ill, mentally retarded, adult and juvenile offenders, alcoholics, and drug abusers. Organizations trying to remedy this situation with CBR's have encountered resistance from the community, particularly in suburban areas. Modeled after a New York project, CRP offers technical expertise and information to organizations before they enter a community. It has identified five major approaches that groups trying to increase CBR's should consider: community acceptance, local zoning legislation, eminent domain, State zoning legislation, and court case assistance. The last three tactics transcend local control and may require a linkage of concerned organizations. The paper describes each approach in detail, including implementation strategies, advantages, and limitations. A summary emphasizes the importance of cooperation among organizations and a regional approach, as well as the necessity for continuing self-appraisal. A total of 43 references are included.

**58** *Impact of Selected Federal Health Programs on Rural Texas.*
Elaine McManus; Mary Walter; Helen Austin and Karen Mountain
Texas Rural Health Field Services Program, Austin.
Sid W. Richardson Foundation, Fort Worth, TX.
Moody Foundation, Galveston, TX.
Meadows Foundation, Dallas, TX.
Trull Foundation, Palacios, TX.
Aug 82, 123p
**SHR-0009684** Available from Texas Rural Health Field Services Program, University of Texas, School of Nursing, 1700 Red River, Austin, TX 78701-1499.

This report describes the health status of rural Texans and reviews the Community Health Centers Program, Migrant Health Program, Rural Health Initiative Program, and the National Health Service Corps (NHSC). It reviews the statistical indices demonstrating the current health status of nonmetropolitan counties in Texas that are medically underserved and thus recipients of federally funded health care programs. It traces the history of the Public Health Service and describes the four programs cited above in terms of their rationale and legislative history. The report focuses on the following aspects of each program: the rules and regulations currently in force, eligibility, the application process, funding criteria, target population, and services provided. The concluding section provides the number and location of counties served, cost per medical encounter, sources of payment, and grant monies for the Rural Health Initiatives, Migrant Health Clinics,

and NHSC in rural Texas. Aggregate results of a survey of rural health care clinics are reported; some data are used to illustrate unique situations at specific clinics. Infant mortality rates and general mortality rates for a 15-year period are compared to demonstrate program impact. The report also discusses impediments to the delivery of health care to rural Texans. In general, the report finds that the Federal programs have benefited the target population, particularly regarding access to primary care for previously underserved areas. However, the clinics will be unable to maintain adequate services without Federal, State, and/or local monetary support. Maps and tabular data are given; 61 references are provided.

**59** *Implementation of Comprehensive Service Systems for the Elderly and Chronically Impaired: A Conceptual Framework and Case Study.*
Rosalie H. Lang
Assistance Group for Human Resources Development, Silver Spring, MD.
Administration on Aging, Washington, DC.
1982, 36p
**SHR-0009710** Pub. in Jnl. of Health And Human Resources Administration v4 n4 p415-450 Spring 1982.

A case study of a model comprehensive service system for providing long-term care for the elderly in Nebraska demonstrates a theoretical framework of systems design and implementation. The theoretical framework is applicable to any human systems. The process involves goals directing information which, in turn, shapes the system's developing parts. The system is also characterized by interdependence (which implies cooperation) and by wholeness (which implies that a change in any part of the system has consequences for the total system and all its parts). For the Nebraska demonstration, researchers had an agreement with the Nebraska Commission on Aging to support implementing a model comprehensive service system in a rural five-county area with a population density ranging from 8 to 33 persons per square mile. Project staff visiting homebound elderly sometimes must drive over 100 miles to visit three or four clients. System development addressed three issues: employment of the elderly individual to control his/her life, targeting of limited public resources to those most in need, and mastering the intergovernmental and cross-categorical governance issues to enhance service delivery and coordination. Technical assistance focused on system design. The system includes case finding and outreach, screening and intake, assessment, and preparation of a care plan, referral, and management. Policy constraints and the value of a systems approach are noted. A total of 17 notes and 6 references are supplied.

**60** *Improving Protective Services for Older Americans: A National Guide Series. Aging Network Role.*
Mary Collins
University of Southern Maine, Portland. Human Services Development Inst.
Administration on Aging, Washington, DC.
Sep 82, 31p
**SHR-0009781** Available from Janet Brysh, University of Southern Maine, Center for Research and Advanced Study, 246 Deering Avenue, Portland, ME 04102.

This guide provides a context to persons within and outside the aging network for understanding the relationship of the aging network to protective service programs. It presents a strategy for their cooperative efforts to shape policy and develop programs at the local level. A particular State or area agency wanting to get more involved in improving adult protective services must decide exactly what its role will be and find the resources to fulfill this new role. State and area agencies can organize community

groups, assess the need for improving an already existing protective services program, advocate for resources, and promote new legislation. Existing adult protective services can be enhanced by senior centers, either by modifying the services of existing centers to integrate the at-risk elderly or by setting up centers especially geared to this population. When virtually no protective services exist for endangered adults, agencies within the aging network may wish to develop a protective services program at the State and/or local level. Agencies must first obtain the authority to deliver such services, define a client population, find sufficient resources, decide on a service delivery format, and define the services that will be offered. Figures and eight references are provided. *See also related documents, SHR-0009780; SHR-0009782–SHR-0009786.*

**61** *Improving Protective Services for Older Americans: A National Guide Series. Community Role.*
Freda Bernotavicz; Jim Bergman; David Schumacher; Howard Segars and Claudia Wink-Basing
University of Southern Maine, Portland. Human Services Development Inst.
Administration on Aging, Washington, DC.
Sep 82, 61p
**SHR-0009782** Available from Janet Brysh, University of Southern Maine, Center for Research and Advanced Study, 246 Deering Avenue, Portland, ME 04102.

Written for program developers, the guide describes strategies for developing community networks to improve adult protective services, discusses the role and need for public education, and identifies a range of innovative community-based programs. A community-based adult protective services "network," which is a viable, low-cost method to mobilize community resources, uses all community and agency services to address individual client needs. All the resources in a community are seen as part of the service delivery system. Three community network types are interagency agreements, special purpose coalitions, and permanent coalitions. Interagency agreements, the most typical kind of network, involve the negotiation of agreements between agencies on how they will collectively serve the client group. Special purpose coalitions – new groups developed to achieve special goals – are of limited duration, while permanent coalitions are organized to supplement and improve protective services over the long run. Organizing a community coalition involves a planning phase, an organizational phase, and an implementation phase. The planning phase builds network membership, includes initial meetings, and develops a strategy. During the organizational phase, the network convenes, interagency agreements are developed, organizational issues are discussed, and a plan of action is developed. The implementation phase involves public education activities, service delivery, legislation, and case review. Public education efforts aim to build community support and attract clients. Community-based programs include emergency services (shelter and caretaker), surrogate services (legal or financial management options), personal care services, housing services, and supportive services. Tables, figures, 11 references, and an index of community programs are provided. *See also related documents, SHR-0009780–SHR-0009781; SHR-0009783–SHR-0009786.*

**62** *Improving Protective Services for Older Americans: A National Guide Series. Family, Neighbors and Friends.*
Freda Bernotavicz
University of Southern Maine, Portland. Human Services Development Inst.
Administration on Aging, Washington, DC.
Sep 82, 52p
**SHR-0009786** Available from Janet Brysh, University of Southern Maine,

Center for Research and Advanced Study, 246 Deering Avenue, Portland, ME 04102.

This guide describes how social workers can use the informal support system – family, friends, and neighbors – to help protective service clients. Care plans for clients can involve members of the informal support network in various roles: providing personal care, giving social support, acting as case manager, and acting as legal surrogate. Programs using the informal support network include those focusing on personal networks, neighborhood networks, natural helpers, mutual aid building, and caregivers. The personal networks approach tries to expand individuals' personal networks by helping them to think about their networks and how they can develop new relationships or reactivate old ones. The neighborhood networks approach attempts to create a caring community where people will look out for each other, while the natural helpers program uses the neighborhood people who are turned to naturally in times of crisis. When a natural network is unavailable, a mutual aid network can be developed in which each individual contributes to the extent possible and receives support to meet any needs. The caregiver program helps caregivers deal with their problems and prevent family burnout. Services include financial support, education, counseling, and group support. Resources and skills needed by family, friends, and neighbors in dealing with the frail elderly are identified. Protective services as a woman's issue is discussed, and policy changes needed to allow a more equitable sharing of responsibility between the formal and informal systems in caring for the frail elderly are presented. These include financial support for home care, more housing options, and financial relief for caregiving families. Tables, figures, and 35 references are provided. *See also related documents, SHR-0009780–SHR-0009785.*

**63** *Improving Protective Services for Older Americans: A National Guide Series. Health Care Role.*
Andrew F. Coburn and Jean Luppens
University of Southern Maine, Portland. Human Services Development Inst.
Administration on Aging, Washington, DC.
Sep 82, 42p
**SHR-0009784** Available from Janet Brysh, University of Southern Maine, Center for Research and Advanced Study, 245 Deering Avenue, Portland, ME 04102.

Health care professionals perform critical roles in assisting the adult protective services worker to assess and treat medical and psychiatric problems that may be contributing to the need for protective services. Health professionals must be able to recognize symptoms of abuse and/or neglect in the elderly for these persons often will not volunteer information. Principles to be followed in identifying a protective problem include allowing enough time for the assessment; including a physician, nurse, and social worker in the assessment; and substantiating evidence indicating the need for protective services. Special attention should be given to the person's residual strengths and resources and to involving the older person and/or the family in the assessment. Problems in conducting geriatric assessments stem from the lack of medical professionals with training and experience in caring for the elderly, some physicians' reluctance to become involved in protective services situations, and the limited availability of adequate geriatric assessment tools. Services provided to protective service clients by health professionals include emergency medical treatment, routine medical treatment, mental health care, and ongoing maintenance and support services. Health professionals working with the elderly should understand such legal tools as civil commitment, guardianship and conservatorship, and protective placement because they may be required to evaluate a patient's mental competency and present their findings to the court. Health professionals can improve protective

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services for the elderly by initiating community education programs and helping to develop an interagency protective services network. Figures and 38 references are included. *See also related documents, SHR-0009780–SHR-0009783; SHR-0009785–SHR-0009786.*

64 *Improving Protective Services for Older Americans: A National Guide Series. Legal Role.*
Arthur B. LaFrance
University of Southern Maine, Portland. Human Services Development Inst.
Administration on Aging, Washington, DC.
Sep 82, 54p
**SHR-0009785** Available from Janet Brysh, University of Southern Maine, Center for Research and Advanced Study, 246 Deering Avenue, Portland, ME 04102.

Directed toward attorneys, judges, and legal advocates, this guide explores legal roles in adult protection: what they are, who fulfills them, and to what ends. Guardianship in its various forms, conservatorship, voluntary and involuntary commitment, protective orders, and power of attorney are discussed in the context of the least restrictive alternative for the client. The guide reviews legal roles in adult protective services – counselor, representative, and client-surrogate – and various voluntary and involuntary alternatives in such cases. The most common forms of involuntary intervention are guardianship of the person, conservatorship of property, and commitment to an institution. Commitment is rare and, it is commonly agreed, should be the last choice. Control of the person is better sought through a less intrusive alternative, usually guardianship or limited guardianship. Guardianship of the person requires a strong showing of incompetency; conservatorship over property – because it is less intrusive – requires a lesser showing of incapacity. A guardian's powers are limited to those specified in the court order. In any guardianship or commitment proceeding, the ward is entitled to proper care. Commitment creates a condition of total dependency by the State and thus imposes a duty of total care upon the State. Recommendations to improve adult protective law and practice focus on liability, obtaining legal counsel in protective cases, legal education in the area of protective services law, and law reform as it relates to adult protective services. Figures and about 60 references and case citations are provided. *See also related documents, SHR-0009780–SHR-0009784; SHR-0009786.*

65 *Improving Protective Services for Older Americans: A National Guide Series. Program Development and Administration.*
Helaine Hornby; Mary Collins and Howard Segars
University of Southern Maine, Portland. Human Services Development Inst.
Administration on Aging, Washington, DC.
Sep 82, 59p
**SHR-0009780** Available from Janet Brysh, University of Southern Maine, Center for Research and Advanced Study, 246 Deering Avenue, Portland, ME 04102.

This guide is directed toward administrators, planners, program developers, and legislators who either currently operate or wish to initiate an adult protective services program. It takes the reader through a step-by-step process of planning, designing, and implementing a program, raising issues and options along the way. Problems facing adult protective services programs include uneven access to protective services, underfunding, and the question of State protective services laws being unduly coercive versus the need for intervention in abusive cases. Basic questions that must be answered in planning such a program focus on defining

the client population; assessing the current availability and adequacy of services; and determining community support, the most appropriate auspices for the program's operation, and the need for statutory authority. In planning the actual services, the administrator must address the service's objectives, how the agency will define its own role in the protective services delivery process, and how other needed services will be obtained. Functions identified as central to the program are obtaining cases, assessing problems, planning services, coordinating service delivery, taking legal action, reviewing progress, and closing cases. In addition, administrators must plan the program, develop policies and procedures, manage staff, administer a budget, and manage information. Community involvement in all phases of the program is emphasized. Observations about the direction of future improvements in adult protective services programs are offered. Illustrations, figures, tables, and 20 references are provided. *See also related documents, SHR-0009781–SHR-0009786.*

**66** *Improving Protective Services for Older Americans: A National Guide Series. Social Worker Role.*
Mary Collins and Arthur B. LaFrance
University of Southern Maine, Portland. Human Services Development Inst.
Administration on Aging, Washington, DC.
Sep 82, 47p
**SHR-0009783** Available from Janet Brysh, University of Southern Maine, Center for Research and Advanced Study, 246 Deering Avenue, Portland, ME 04102.

The guide addresses the key decisions social workers must make in casework situations, describes some of the dilemmas social workers confront, and suggests practice improvements. The protective social worker, in assessing the client's well-being, should determine the answers to five questions: is this a protective service client, what is the best case plan, how should the plan be implemented, can the case be terminated safely, and what is the long-term plan to prevent recurrence of the protective crisis? Four types of plans, ranging from least restrictive to most restrictive, include the self-care plan, the informal supportive plan, the formal supportive plan, and the surrogate plan. In adult protective services, several kinds of case review should be performed, including worker review, external review, and judicial review. Techniques that social workers are urged to use in dealing with protective clients encompass bargaining, persuasion, using professional authority, focusing on client strengths, and waiting for the client to make decisions. Ways of working with the client's neighbors, law enforcement, and other professionals in the community include mediation, agreements, team work, and using community organizational skills. Legal aspects of adult protective services can be improved by assuring that clients always have legal counsel in court hearings, improving documentation, and improving skills and knowledge about going to court. Problems social workers experience in following agency policy, professional standards, and the law revolve around personal liability, value conflict between the law and social work, and differences between bureaucratic and professional standards of practice. Case examples, figures, tables, and 25 references are provided. *See also related documents, SHR-0009780–SHR-0009782; SHR-0009783–SHR-0009786.*

**67** *Improving Public Management Through Capacity-Building: A Review of the Literature.*
Beth Walter Honadle
Dec 81, 25p
**SHR-0009702** Available from Council of Planning Librarians, 1313 East 60th Street, Chicago, IL 60637.

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This report reviews literature on capacity building – that is, the ability of local communities and areas to manage their problems. It synthesizes most of the available literature on the subject, analyzes the concept of management capacity, promotes sound principles of capacity building, and advances systematic study in this area. Capacity building activities can improve the ability of local governments and communities to manage their problems by anticipating and influencing change, making informed decisions about policy, developing programs, attracting and absorbing resources, managing resources, and evaluating activities. The principles of capacity building include gaining the confidence of the technical assistance recipient; funding capacity building projects from a combination of Federal, State, and local sources; rewarding local officials for implementing desired change; and cultivating the active involvement of officials at the local level. Additional principles call for demonstrating previous success with a proffered innovation, promoting techniques that are appropriate for the size and type of government concerned, minimizing risks to the recipient, and securing a commitment to capacity building from the local chief executive. Two reasons for studying capacity are to ascertain an organization's current capability and to gain information about the effectiveness and specific programs in achieving their purpose of building management capacity. Charts, footnotes, and a 42-item bibliography are provided. *CPL Bibliography no. 69.*

**68** *Improving the Accountability and Performance of Government.*
Bruce L. Smith and James D. Carroll
Brookings Institution, Washington, DC.
1982, 123p
**SHR-0009804** Available from Brookings Institution, 1775 Massachusetts Avenue NW, Washington, DC 20036.

This volume contains the edited proceedings of a 1-day seminar in recognition of the contributions to American government made by Elmer Staats, former Comptroller General of the United States. It reviews the major developments in national public administration during Staats' 40-year public service career: the growth of presidential management, budgetary reform, the establishment of a strong merit civil service system, and significant improvements in legislative and executive accountability and oversight. Major papers are accompanied by commentary from other seminar participants. The first presentation outlines major public administration trends between 1940 and 1980, delineating landmark actions relating to personnel, budgeting, central clearance, legislative oversight, and executive management. Staats' talk reviews governmental performance in perspective, identifying achievements and challenges with emphasis on the roles of the Office of Management and Budget and the General Accounting Office. The paper on the senior executive service questions the fundamental premise of the generalist public administrator by suggesting that the demonstrated command of essential program knowledge is equally important with managerial skill in developing and selecting top-level career program managers. The speaker on accountability and oversight tackles and resolves the paradox of requiring accountability from ostensibly independently operating agencies. Another paper reviews the progress of the budgetary process over the last half-century in terms of presidential responsibility, controllability, stabilization policy, congressional budgetary reforms, and the reconciliation process. The final paper delineates 16 specific recommendations for improvement in the President's managerial capacity made by the National Academy of Public Administration for the presidency of the 1980's and seeks to identify implementation efforts. Footnotes are given, and seminar participants are listed. *Presented at a seminar in honor of Elmer B. Staats at the Brookings Institution on May 6, 1981. Brookings Dialogues on Public Policy.*

**69** *Improving Youth Employment Prospects: Issues and Options.*
Sandra Christensen
Congressional Budget Office, Washington, DC. Human Resources and Community Development Div.
Feb 82, 78p
**SHR-0009757** Available from the Superintendent of Documents, Government Printing Office, Washington, DC 20402, order number 052-070-05688-6.

An analysis of the youth employment problem and current Federal programs that affect the youth labor market is followed by a discussion of several Federal options for the future. Unemployment among white youths was twice as high as the national average in 1981, while unemployment among nonwhite youths was over 4 times as great as the national average. The two main aspects of the youth employment problem are the difficult transition from school to work for all youths and the particular problem faced by some youths, especially those who are black and poor or who lack basic academic skills. Efforts to deal with youth employment problems can increase the employment demand for youths, enhance youths' job qualifications, or improve youths' ability to handle the transition from school to work or from one job to another. Potential methods for increasing employment demand are to leave the minimum wage unchanged; expand employment subsidies; and expand work experience programs, particularly the Targeted Jobs Tax Credit program. Options for enhancing job qualifications include expanding job training programs and redirecting Federal expenditures for secondary education. Possible ways of promoting the transition from school to the labor market include placement assistance in high schools and training in conducting job searches. Tables and footnotes are provided. *A CBO Study.*

**70** *In Search of the Paper Children.*
Ed Leefeldt
Center for Analysis of Public Issues, Princeton, NJ.
Edna McConnell Clark Foundation, New York.
1982, 118p
**SHR-0009676** Available from The Center for Analysis of Public Issues, 16 Vandeventer Avenue, Princeton, NJ 08540.

This study examined the review process for placements of foster children in New Jersey to determine whether the process set forth in the 1978 Child Placement Review Law is being followed, if the reviews have improved case planning and services to children, and if the process has improved outcomes for children in foster care. The law provides for placement reviews to be performed by 5-member citizen review boards in each county. The citizen reviews are preceded and followed by judicial reviews. The analysis revealed that many children in placement are not being reviewed. Children placed by agencies other than New Jersey's Division of Youth and Family Services (DYFS), and 42 percent of the sample placed by DYFS, had not been reviewed. Other problems included delays in performing reviews, lack of personal testimony from natural parents, inappropriate forms, and late court determinations following the citizen review. The review process did not reduce the amount of time spent in foster care or the number of placements. However, the review law has improved case planning and record-keeping. The law should be strengthened to assure a review for all children in foster care, a pilot program should be established to test the concept of preplacement reviews, and the number of boards should be linked to the number of cases heard rather than to the number of juvenile judges. In addition, board members should be trained before or at the start of service. The system is well worth improving, because it creates advocates for children and is relatively inexpensive to operate. Figures, tables, and footnotes are given. Appendices discuss the study method and questionnaire results and compare New Jersey's law with standards in other States.

**71** *Informal Supports in Long Term Care: Implications and Policy Options.*

Lucy Y. Steinitz
Chicago Univ., IL. Center for the Study of Welfare Policy.
Administration on Aging, Washington, DC.
National Conference on Social Welfare, Washington, DC.
Feb 81, 31p
**SHR-0009658** Available from National Conference on Social Welfare, 1730 M Street NW, Washington, DC 20036.

This paper examines social, economic, and health care supports provided by relatives and friends to disabled chronically ill older people and then outlines two policy strategies to encourage informal support systems. Studies have shown that most elderly prefer turning to family and friends for help rather than the formal service system. The family is the major source of aid for most impaired elderly, particularly in the areas of emotional gratification, household management, and health care. Women and close relatives predominate as family caregivers, and informal caregiving is found more frequently among lower income and working class people than among high-income groups. Restrictions on personal time and freedom are the most common complaints of caregivers, followed by emotional and physical health problems. Currently, financial disincentives and inadequate community support help push many caregivers beyond their endurance, inducing premature institutionalization. These findings suggest that government and policymakers should encourage informal supports whenever possible. The paper presents two policy options to be pursued separately or in combination. The first is a system of State and Federal tax incentives involving reduced property taxes for the elderly, income tax deductions for long-term care expenses like nutrition services and home maintenance, and a 20-percent tax credit for disabled dependent care. The second strategy strengthens informal supports through service programs and reimbursement mechanisms. This approach includes respite care, age-segregated housing, community programs, and a voucher system allowing the elderly freedom of choice in purchasing services. A total of 53 footnotes are included.

**72** *Information Systems Manual for Human Service Transportation Systems.*

David J. Evak and Richard Weidenheft
United Services Agency, Wilkes-Barre, PA.
Office of Human Development Services, Washington, DC. Transportation Initiative Office.
Pennsylvania Dept. of Public Welfare, Harrisburg.
May 82, 115p
**SHR-0009689** Available from United Services Agency, Administrative Offices, 111 North Pennsylvania Blvd., Wilkes-Barre, PA 18701.

This manual for providers of coordinated human service transportation presents a step-by-step guide for developing a management information system (MIS) that satisfies internal and external reporting and accountability requirements, is administratively expedient and cost effective, and serves as a basis for developing uniform accounting procedures. A transportation system must collect three types of data – client service, financial, and operations data – all of which can be used to increase the operation's efficiency and effectiveness. The manual instructs on how to complete the many forms needed to collect data and presents the necessary revenue codes and vehicle information. All three types of data must then be summarized; the text shows how to summarize units of service for simple and detail billing, passenger trips, time and mileage data, vehicle activity, and expenses. Transportation system operations can then be evaluated by calculating per-

formance indicators for productivity, vehicle use, cost of providing transportation, and financial activities. In addition, the manual explains how to allocate costs; unit costs should be calculated periodically to adjust for changes in productivity and vehicle use, expense increases or decreases, demand changes, or other factors. Finally, the text provides sample forms and formats for both external and internal reports (the MIS output). This information can be used to identify system dysfunction, improve system functioning, compare systems, and plan for the future. A glossary and 24 references are appended.

**73** *Innovative Utilization of Older Persons in Volunteer Services Programs: Six Hospitals Report on Model Projects.*
Hospital Research and Educational Trust, Chicago, IL.
Edna McConnell Clark Foundation, New York.
1981, 94p
**SHR-0009777** Available from Hospital Research and Education Trust, 840 North Lake Shore Drive, Chicago, IL 60611.

The six eastern and midwestern hospitals participating in the Older Volunteers Program in Hospitals successfully implemented a variety of programs by matching the talents and skills of older adults with community health needs. The PATH (People Activated Toward Health) program at South Nassau Communities Hospital, Oceanside, N.Y., involves over 200 older volunteers in a medical self-help, screening, and referral program. The Volunteer Cancer Research Assistants at M.D. Anderson Hospital and Tumor Institute, Houston, Tex., perform laboratory, library, statistical, computer, and photography assignments that enable scientists to expand their research efforts. The Health Education Volunteers (HEV) at Mount Auburn Hospital, Cambridge, Mass., work with hospital staff members and community agencies, such as schools and senior centers, in presenting health education and promotion programs. STAGES (Seniors to Advise, Grow, Educate, and Service) program at Mount Sinai Hospital, Minneapolis, Minn., is designed to aid individuals in the community suffering from the effects of change and loss. The Poison Control Center Volunteers at the Cardinal Glennon Memorial Hospital for Children, St. Louis, Mo., extends the services of the St. Louis Poison Control Center by assisting in research, providing telephone followup on poisoning cases, and helping to staff a 24-hour emergency hotline. Volunteers in the Health Education Project (HEP) at St. Lawrence Hospital, Lansing, Mich., developed a health education center at the hospital that serves inpatients and outpatients in the tricounty area. Statistical tables, sample forms and programs, 14 selected publications and papers, 31 references, and 5 additional resources are provided. *Series on Aging.*

**74** *Instrument-Based Program Monitoring System: A New Tool for Day Care Monitoring. Volume 1: Guide for Policymakers.*
Richard J. Fiene and Mark G. Nixon
Pennsylvania Dept. of Public Welfare, Harrisburg. Children's Services Monitoring Transfer Consortium.
Office of Human Development Services, Washington, DC.
Aug 81, 12p
**SHR-0009674** Available from Pennsylvania Office of Children, Youth and Families, 1514 North Second Street, Harrisburg, PA 17120, Attn: Dr. Richard Fiene.

This manual presents a methodology for State monitoring of human service programs; the methodology uses checklists or special kinds of questionnaires to structure monitoring interviews and site visits. The guide also describes the positive results that Pennsylvania has achieved by implementing the monitoring system in the field of day care services for children.

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An instrument-based program monitoring (IPM) system differs substantially from the narrative site visit reports more often used in monitoring. IPM uses highly specific questions that incorporate pertinent State regulations in a simplified format that is easily completed and shows both providers and State agencies just how well the provider is complying with requirements. The IPM system assigns weights to the questions so that scores reflect the relative importance of the regulations. The IPM system is ideally suited to achieving such goals as ensuring equitable and enforceable monitoring to meet a desired level of child health and safety and ensuring that day care promotes child development. Pennsylvania's system, which was introduced in 1978, has produced cost reductions, improved program performance, an improved regulatory climate, and improved information for policy and financial decisions. Pennsylvania's system is also linked with the State's financial and statistical reporting systems. States considering an IPM system should evaluate their social services environment, review materials on IPM and the experience of other States, evaluate costs and potential benefits of IPM, make a State commitment to implement the system, assess regulations and legal requirements, and develop an implementation plan. Figures, tables, a list of 10 references, and addresses of sources of further information are supplied. *See also volume 3, SHR-0009675.*

**75** *Instrument-Based Program Monitoring System: A New Tool for Day Care Monitoring. Volume 3: Guide for Developing the the Indicator Checklist.*
Richard J. Fiene and Mark G. Nixon
Pennsylvania Dept. of Public Welfare, Harrisburg. Children's Services Monitoring Transfer Consortium.
Office of Human Development Services, Washington, DC.
Oct 81, 22p
**SHR-0009675** Available from Pennsylvania Office of Children, Youth and Families, 1514 North Second Street, Harrisburg, PA 17120, Attn: Dr. Richard Fiene.

This manual provides instructions for developing an indicator checklist as part of an instrument-based program monitoring (IPM) system based on Pennsylvania's experience using its IPM system for monitoring child day care services. The guide is for managers and technical specialists responsible for managing and improving monitoring systems for human services. An indicator checklist is a questionnaire or checklist that contains selected predictive items from a longer, comprehensive instrument used by a State to monitor service providers' compliance with State requirements regarding health, safety, and other matters. Such a checklist is part of the IPM system, which uses objective, specific questionnaires or checklists rather than narrative site visit reports as the basis for conducting reviews. The indicator checklist is intended as a complement rather than a substitute for the comprehensive instrument. The checklist can be used as a screening device or as an interim review instrument. The steps required to develop an indicator checklist include appraising the comprehensive instrument, obtaining at least 1 year of data on the comprehensive instrument, using the recommended formula to identify good predictor items, adding essential items, and constructing the indicator checklist. Successful implementation of the checklist depends on confidence in the checklist,clear expectations on the part of administrators and providers, and the organization of the implementation effort. Figures and appendices presenting additional instructions and examples from the Pennsylvania system are provided. *See also volume 1, SHR-0009674.*

**76** *Inter-Sectoral Cost Comparisons: Day Care for the Elderly.*
Martin Knapp and Spyros Missiakoulis
1982, 20p
**SHR-0009737** Pub. in Jnl. of Social Policy v2 n3 p335-354 Jul 1982.

This study of public and nonpublic day care services for the elderly in England and Wales finds that small voluntary (nonpublic) units are cheaper than public units, but larger voluntary units are probably more expensive than local authority units of a similar scale. The day units include day centers, day hospitals, sheltered workshops, and clubs for the elderly. Questionnaires were sent to 120 of these units, resulting in 55 usable responses for the cost function analysis. The cost measure used was gross operating cost per attendance. A number of cost functions were estimated by multiple regression analysis. The 55 day units for which the cost functions were estimated were owned or run by either a local authority social services department (20 units), an area health authority (24 units), or a voluntary organization (11 units). The average operating cost per daily attendance in these units in 1976 to 1977 ranged from 1.16 British pounds for voluntary units to 7.53 British pounds for health service units. The estimated cost function reveals how day care costs vary systematically and significantly with the users' dependency characteristics, the units' activities, the attendance levels, and the sector in which the unit is located. Figures, tables, 13 notes, and about 23 references are included.

**77** *Interorganizational Relations: A Sourcebook of Measures for Mental Health Programs.*
Joseph P. Morrissey; Richard H. Hall and Michael L. Lindsey
New York State Office of Mental Health, Albany. Special Projects Research Unit.
National Inst. of Mental Health, Rockville, MD.
1982, 119p
**SHR-0009773** Available from the Superintendent of Documents, Government Printing Office, Washington, DC 20402, order number 017-204-01133-9.

Prepared for evaluators of interorganizational aspects of mental health services, this sourcebook presents an overview of 26 concepts and 35 measures currently used in interorganizational research. An introduction reviews the history of interorganizational research and discusses the relevance of relations between organizations for mental health system evaluations. The theoretical and substantive foci of this field are highlighted, with attention to the three basic forms of interorganizational relationships – dyads, sets, and networks. Also discussed are measurement considerations, including units of analysis, source and types of data collection, number of observations, validity and reliability, and generalizability of findings. Methods used to review literature published in the United States between 1970 and 1981 are outlined, as is the analytical framework developed to organize and profile individual concepts and measures. Subsequent chapters present detailed profiles of these concepts and measures arranged in the following categories: environmental context, situational factors, bases of interaction, resource flows, transaction structures, transaction processes, and outcomes. Each chapter first describes the significance of the analytical category and its major subconcepts and then profiles each subconcept in terms of conceptualization and use, measure, study descriptions, data collection, computation, methodological adequacy, and key references in the literature. The document includes figures, an index of the concepts and measures, and about 190 references. *Mental Health Service System Reports, Series BN no. 2.*

**78** *Introduction to Information Systems for the Network on Aging. Manual II.*
Fred J. DeJong
National Association of State Units on Aging, Washington, DC.
Administration on Aging, Washington, DC.
TSDI, Inc., New York.
Aug 82, 57p
**SHR-0009669** Available from National Association of State Units on

Aging, 600 Maryland Avenue SW, Suite 208, Washington, DC 20024.

This manual, one of four designed to support the development and use of information systems in State and area Agencies On Aging, is intended to introduce staff of aging networks to the problems associated with the development and operation of automated information systems. The three major functions of an information system are input, storage and processing of data, and output of data. Most systems are developed for use in fiscal accounting, client tracking and case management, planning and research, monitoring and evaluation, and satisfying the information requirements of funding sources. The development of an effective information system involves defining the current information systems, identifying information needs, determining system requirements, reviewing alternative systems available, defining the new system management and obtaining approval, developing and implementing the new system, converting user records, operating the system, and maintaining and updating the system. Factors to be considered during each of the nine steps are detailed. An appendix discussing data and information needs for aging units is designed to aid in identifying information needs during the system development process. *See also manual I, SHR-0005740.*

**79** *Investigation Into the Quality of Service Provided by Telephone Hotlines for Family Planning Services.*
Diana Baxter and J. I. Williams
5 Aug 80, 6p
**SHR-0009767** Pub. in Canadian Jnl. of Public Health v73 n3 p194-199 May/Jun 82.

An evaluation of two birth control telephone hotlines in Toronto, Canada, found that the counseling skills and information accuracy were high for both agencies. The Family Planning Services' Hotline, run by the Family Planning Services Division of the Department of Public Health in the City of Toronto, was staffed by paid community workers. The Planned Parenthood Hotline was staffed by volunteers. Using professional actors as simulated callers and two panels of judges, the evaluation assessed and compared the paid and volunteer counselors using quality of counseling skills (warmth, empathy, sincerity) and accuracy (extent of knowledge and appropriateness of information given) as the criteria. Appropriate scripts were written for typical hotline calls, such as a teenager requesting general information on birth control, a young woman with questions about the pill, and a woman needing counseling about pregnancy. The calls were placed at different hours over a 2-week period and were recorded for the judges. Both the professional and volunteer counselors were rated uniformly high regarding the quality of concern shown to callers. The volunteers, as a group, had limited training in family planning counseling and hotline experience compared to the Family Planning Services staff. Counselors in both agencies tended to appear rather professional, disinterested, and too anxious to instruct. The study findings imply that volunteer agencies can provide services similar to government services more economically, since staff costs are not included. Six tables and seven references are provided.

**80** *Involving Staff in Nursing Quality Assurance.*
Carol A. Harmon
1980, 5p
**SHR-0009824** Pub. in Quality Review Bulletin v6 n11 p26-30 Nov 80.

The quality assurance (QA) program at the Huron Road Hospital in East Cleveland, Ohio, was designed to help nurses understand the need to participate in the development of nursing care standards and the need to use these standards to formulate nursing care plans. Previous nursing care assessments only revealed that standards of care were inadequate. Moreover, these standards often contained goals irrelevant to patient outcome. Under the new QA program,

inservice classes were conducted in three phases covering standards, process, and evaluation of nursing care. A pretest administered to 158 nurses revealed that only 19 percent understood the hospital's nursing QA program. In class discussions, nurses agreed that those most directly involved in providing patient care should develop the standards. Nurses identified problems with care planning and documentation and were encouraged to provide suggestions for solutions. They suggested developing a program of monthly nursing care clinics to review discharge planning and problem solving, adopting problem-oriented nursing records, and revising care standards. Instructors also detailed evaluation procedures to familiarize staff with the kinds of approaches (e.g., profile analysis) that the program will take and data sources (e.g., staff interviews, incident reports) that will be used in the future. Following the classes, a posttest was given showing dramatic improvement in most questions. The program resulted in a better working relationship between the QA coordinator and the nursing staff. Nurses feel more secure about reporting care problems. The report notes other positive developments resulting from the program. The questionnaire and findings are included.

**81** *Isolationism in Adolescent Research.*
Robert E. Grinder
1982, 10p
**SHR-0009722** Pub. in Human Development v25 n3 p223-232 May/Jun 1982.

The fundamental problem of research in adolescence, given its many origins and sources of dissemination, is less an inability to produce substantive research than to perceive the research that exists. The problem, which tends to isolate researchers from one another, is reviewed here in respect to the scope of available scholarship. The article considers five sources of empirical inquiry encompassing conventional research paradigms and new approaches associated with ecological psychology, youth policy, action programs, and status reviews. It cites several large-scale traditional studies involving different populations, tests of multiple hypotheses, and experimental treatments appearing in the literature and notes that the trend in large-scale research is certain to accelerate. It notes that a new wave of research on behavioral settings of adolescents is taking place and that policy researchers are debating several lively issues, such as student rights in high school, contracting, and abortion. Moreover, social scientists can learn about action research in adolescence via conferences, newsletters, and published status reviews. These and other research efforts will be dependent on the social and economic circumstances shaping public interpretations on the significance of adolescence. Footnotes and 26 references are supplied. *Paper based on an address presented at the conference, Research on Children and Adolescents in the Family Context, sponsored by the Interagency Panels for Research and Development on Early Childhood and on Adolescents, Administration for Children, Youth, and the Families, Washington, DC, May 19, 1980.*

**82** *Issues in Rural Child Welfare.*
Joanne Jankovic
1981, 4p
**SHR-0009789** Pub. in Human Services in the Rural Environment v6 n3/4 p4-7 Summer/Fall 1981

Although urban-type programs are usually inappropriate for dealing with rural child welfare problems, child welfare workers in rural areas are often expected to provide the same array of services to children and their families as their urban counterparts. However, the unique aspects of many rural areas have implications for rural practice – the interface between juvenile justice agencies and child welfare programs because of the lack of alternative out-of-home care facilities, rural poverty, and the changing roles of many rural women in becoming active job-

seekers. Added demands are placed upon child welfare agencies in providing adequate services when they do not have the necessary funding. Funding will continue to be a problem, especially if block grants become a reality, since rural areas will continue to lose out by not having the necessary political influence in resource allocation. One table, one photograph, and eight references are included. Author abstract modified.

**83** *Issues Perceived as Barriers in the Implementation of the CSS Concept.*
Susan Steindorff
New York State Office of Mental Health, Albany. Community Support Project.
National Inst. of Mental Health, Rockville, MD.
Jun 80, 10p
**SHR-0009686** Available from New York State Office of Mental Health, 44 Holland Avenue, Albany, NY 12229.

The three Community Support Systems (CSS) programs in New York, each serving the chronically mentally ill, face fundamental service delivery problems. Inadequate transportation is an overriding problem. It could be improved with Federal encouragement of additional grant awards, more vehicles assigned, and transportation studies establishing this need. The lack of residential alternatives, such as independent apartments, is a problem best overcome by modifying HUD regulations to encourage small-scale scattered site housing and prohibiting zoning laws that exclude residential facilities for the handicapped. The three programs also need ongoing staff orientation, particularly in understanding CSS components, their interrelations, and staff job descriptions within each. Certain public assistance programs' allowances are too small to cover clients' personal needs or discourage clients' motivation toward independence and competitive employment. Personal allowances should be increased and benefits gradually terminated. The programs should identify and coordinate programs for those populations requiring special services, broaden eligibility criteria, increase community awareness of client needs, and work toward a uniform budgeting and reporting system. Ten references are appended.

**84** *Juvenile Restitution: A Dynamic and Challenging Alternative.*
David L. Tank and Mary C. McEniry
Wisconsin Dept. of Health and Social Services, Madison. Bureau for Children, Youth and Families.
Law Enforcement Assistance Administration, Washington, DC. Office of Juvenile Justice and Delinquency Prevention.
1 Dec 79, 17p
**SHR-0009647** Available NTIS PC$06.00/MF$4.00

This booklet provides a brief history of restitution and then describes Wisconsin's juvenile restitution program, a pilot project in 10 court jurisdictions funded by the Federal Law Enforcement Assistance Administration in 1979. Wisconsin was already recipient for this grant because it had recently revised its children's code to include clear procedures allowing a juvenile to make restitution for his or her offense. Restitution not only satisfies the victim, but is an important rehabilitation tool that holds juveniles accountable for their actions. Restitution can take three forms: monetary payment, community service, or service to the victim. Following a summary of juvenile court procedures, this report identifies the various stages when restitution can be ordered. It then outlines the responsibilities of the local juvenile restitution projects who organize and monitor the restitution activity. Only those youths judged delinquent or found responsible for criminal acts are eligible for the program at present. The discussion of staffing and funding considerations emphasizes that a full-time staff is required and that restitution represents a bargain compared

to other rehabilitation methods. The future of juvenile restitution depends on community support, governmental action, judges' support, and program evaluations. Addresses of the Wisconsin project's central and regional offices are appended. *Wisconsin Juvenile Restitution Project.*

**85** *Living at Home: The Roles of Public and Informal Supports in Sustaining Disabled Older Americans.*
Alan Sager; Sylvia Pendleton; Celia Lees-Low; Deborah Dennis and Victor Hoffman
Florence Heller Graduate School for Advanced Studies in Social Welfare, Waltham, MA. Levinson Policy Inst. Administration on Aging, Washington, DC.
Mar 82, 494p
**SHR-0009677** Available NTIS PC$34.50/MF$4.00

One hundred elderly persons in Massachusetts were studied to determine the actual levels of home care they were receiving as well as desirable levels of care. Half of the sample were being served by home health agencies and half by Massachusetts' home care corporations. Each client was assessed three times at 3-month intervals to determine their needs with respect to mobility, personal care, nutrition, household maintenance, supervision, and protection and advocacy. The subjects were also assessed with respect to their medical, functional, and emotional well-being. Clients, caregivers, physicians, nurses, and social workers independently indicated the types and amounts of service they thought each patient needed to live at home in a safe, adequate, and dignified manner. The professionals, clients, and family members agreed mildly with one another about needed service areas. Professionals tended to recommended more publicly paid help than did the other groups. Families were providing almost three-quarters of all help, while professionals thought that they should provide only 59 percent of the help. The publicly funded services seemed to be fairly well targeted to those in need. The publicly funded services also appeared more to support families than to supplant them in their caring efforts. It is recommended that organized efforts to mobilize additional informal support to elderly persons be organized to reassure the Congress that a program for Federal funding of home care would be affordable. Tables, a list of about 140 references, and appendices presenting forms and worksheets are supplied.

**86** *Local Church as Support for the Elderly.*
Lucy Y. Steinitz
1980, 11p
**SHR-0009704** Pub. in Jnl. of Gerontological Social Work v4 n2 p43-53 Winter 1981.

Based on secondary analysis, interviews, and participant observation in the midwestern community of Laketown, this study describes the emergency and ongoing services provided by local parish churches around issues of loneliness, crisis readjustment, home health care, and emergency needs. Churches provide emotional security and comfort to older people suffering from depression and malaise but offer few material services. Middle-aged and older lay women volunteers provide most church services, so that many elderly congregants act simultaneously as both recipients and providers of church social services. Some churches effectively respond to short-term crises requiring emergency food, housing, or personal care services. Three Laketown churches have organized telephone reassurance programs providing isolated elderly congregants with regular communication. They emphasize friendship ties among older congregants. Churches often function as family surrogates, filling the same role as a family in reducing anomie and in providing concrete help and psychological assurances in times of need. They use family-like terminology, the same type and informal structure of ser-

vices that families provide, and similar service distribution based on individual factors and close personal ties. They also lack firm linkages with social agencies and government institutions. Policymakers and agency workers should take into account the parish church's role in providing informal and community supports for the elderly. An appendix includes definitions of services churches provide; footnotes and 11 references are supplied.

**87** *Long Term Care Costs in a Consolidated Model.*
John Shen and Rick T. Zawadski
On Lok Senior Health Services, San Francisco, CA. Community Care Organization for Dependent Adults.
Administration on Aging, Washington, DC.
Health Care Financing Administration, Washington, DC.
California State Health and Welfare Agency, Sacramento.
Dec 81, 21p
**SHR-0009680** Available from On Lok Senior Health Services, 1441 Powell Street, San Francisco, CA 94133.

This report describes the cost experiences of the On Lok Community Care Organization for Dependent Adults (CCODA), a model of comprehensive, coordinated, community-based care for the elderly in San Francisco, Calif. The CCODA uses a multidisciplinary team of professionals to coordinate and deliver essential medical, social, and supportive services to the community's long-term care population. This study analyzes cost and assessment data from a sample of 269 elderly persons served between January and June 1981. The average cost per day for all services was $37.68, a value competitive with the costs of traditional long-term care. The consolidated model of service delivery resulted in a distribution of resources away from institutional care to community-based care and a more balanced relationship between medical and social services. The participants' level of care classification was linearly related to the average daily cost of services, demonstrating that long-term care costs are determined by the composition of the service population. Degree of functional dependency and degree of illness were correlated significantly with the costs of day care services, in-home services, and skilled nursing facilities. The cognitive impairment index positively correlated with nursing home costs, while social functioning correlated with both hospital and nursing home costs. Given the population under study, public funding sources such as Medicare and Title XX would shoulder slightly over three-quarters of the total costs, with State and Federal Governments sharing the burden equally. Tables and 11 references are included. *Technical report no. 302.*

**88** *Management Corporation Makes Joint Hospital Project Possible.*
Stephen E. Foreman; James D. Knotter; Peter M. Fronizer and John C. Fitch
1980, 5p
**SHR-0009825** Pub. in Hospitals v54 n23 p57-61 1 Dec 80.

The consolidated management arrangement used by two Cleveland, Ohio, hospitals has allowed them to extensively renovate one of the hospitals and to build a 200-bed suburban hospital. St. John Hospital, a religious allopathic hospital, and Bay View Hospital, a nonsectarian osteopathic hospital, formed the Westlake Health Campus Association. The Association is controlled equally by St. John Hospital and West Shore Health Center, owned by Bay View Hospital. The basic agreement among the hospitals establishes the ownership, organization, and control elements for the new suburban hospital, including organization of the management corporation, the Campus Association. The agreement emphasizes equality of participation, control, rights, and obligations. The Campus Association is primarily responsible for the

design, construction, equipping, and financing of the new hospital. To implement the basic agreement, the Campus Association has been organized as a not-for-profit corporation. The Campus Association will appoint a single medical staff of osteopathic and allopathic physicians; organize the new hospital's administrative policies and procedures: apply for licenses, certificates, and accreditations; and arrange for contracts with staff and suppliers. The Association, prior to completion of the hospital, also will develop financial planning and budgeting policies, financial reporting standards, and internal fiscal controls.

**89** *Management of Hard Times: Budget Cutbacks in Public Sector Organizations.*
Todd D. Jick and Victor V. Murray
1982, 29p
**SHR-0009754** Pub. in Organization Studies v3 n2 p141-169 1982.

The literature on organizational decline in public sector organizations is reviewed, with emphasis on the distinctions between decision processes and their outcomes, between perceived and objective aspects of cutbacks, between strategic decision outcomes and other outcomes, and between the short-term and long-term impacts of continuing decline. The seven basic internal response strategies to budget cutbacks are rational priority planning, externally oriented political cuts, internally oriented political cuts, across-the-board cuts, delay, abdication, and passivity. Strategies to stop externally imposed cutbacks include rational argumentation, seeking of alternative sources of funds, external political threats, external political promises, the forming of coalitions, the joining of coalitions, and passivity. Organizations are likely to choose several of the possible strategic decision responses and will use only those strategies seen as consistent with the causes of the cuts. Unresolved issues regarding responses to cutbacks include the changes in response patterns over time and whether perceived severity or perceived time pressure is the more difficult aspect of a crisis. Further research to examine these and other issues is recommended. Seventy-nine references are listed.

**90** *Management Trends in the Human Services in the 1980's.*
Rosemary C. Sarri
1982, 12p
**SHR-0009800** Pub. in Administration in Social Work v6 n2/3 p19-30 Summer/Fall 1982.

Management strategies and tasks in the 1980's must be analyzed and ordered on a priority scale to determine what is most appropriate for each organization. One issue confronting human service organizations is identification of the preferred conceptual model of the organization in order to develop management strategies and directions. This model can be taken from management technologies found in other organizations, although it must be recognized that there are critical differences between human service organizations and those that pursue profit and individual goals. Other issues concern declining resources available for social welfare; the need for program evaluation, worker accountability, and consumer satisfaction; institutionalized racism; and others. In the 1980's, private/voluntary agencies are likely to become more involved in social service delivery, and organizations are likely to be pressured to both centralize and decentralize. Pressures for staff and client participation in the decision-making process are likely to grow, information systems will proliferate, budgetary constraints will become more severe, and social service delivery in industrial settings will expand. A total of 41 references are supplied.

**91** *Managing Computers in Health Care: A Guide for Professionals.*
John Abbott Worthley
Seton Hall Univ., South Orange, NJ.
1981, 252p
**SHR-0009716** Available from Health



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**91**

Administration Press, Department 88, 1021 East Huron Street, The University of Michigan, Ann Arbor, MI 48109.

This book is designed to help health care professionals tame computer technology. It is written for hospital administrators, doctors, nurse supervisors, and other users of computer technology who are not completely comfortable with printouts. Three realities underlie the book's focus: the pervasiveness of computers, the potential benefits computers can offer in health care, and the disappointing experiences encountered by health care professionals and others who have installed computers. Computer usage in health care has been beset by fiscal, operational, organizational, psychological, legal, and sociopolitical problems. Chapters on technical aspects discuss information concepts (data versus information, characteristics of information, information system, management information system) and computer technology. Succeeding chapters examine the process of systematic thinking; managing organizational impacts, including the computer as a focus of organizational change in a hospital; and managing and dealing with resistance to computers. Maintaining computer security, maintaining information privacy, and understanding social impacts constitute the concluding topics of the book. The text of each chapter provides a comprehensive but concise treatment of the subject, while ensuing readings offer a more indepth view. Diagrams, footnotes, chapter references, a glossary, and an index are supplied.

**92** *Managing Voluntary Organizations: A Manual for Community Development and Management of Voluntary Organizations.*
Richard J. Gallagher
New York State Association of Councils on Alcoholism, Inc., Buffalo.
National Inst. on Alcohol Abuse and Alcoholism, Rockville, MD.
1979, 334p
**SHR-0009803** Available from New York State Association of Councils on Alcoholism, Inc., 119 Washington Avenue, Albany, NY 12210.

This manual presents a detailed step-by-step plan to facilitate the development of community alcoholism programs as well as specific strategies and resources to improve management capabilities of such organizations. The text describes the voluntary alcoholism sector at the local, State, and national levels and delineates procedures for establishing an effective council on alcoholism. In addition, suggestions are made for monitoring a council's growth and performance, and management standards and guidelines for alcoholism councils are listed. Considerations addressed in the organizational outline include the steering committee, the constitution and bylaws, incorporation and tax-exempt status, employer identification number, board of directors, and the program's role. Still others are the volunteer program, committees, job descriptions, salary plans, personnel policies and procedures, funding proposals and sources, and contracts. Also addressed are the executive director's role; bank accounts; office space and equipment; insurance coverage; bookkeeping system; fiscal and programmatic reporting; publicity; affiliations; and subscriptions, publications, and films. Staff training and evaluation conclude the organization guidelines. The appendix contains illustrative material pertaining to the above topics. Tabular data are included.

**93** *Marketing Health and Human Services.*
Robert Rubright and Dan MacDonald
1981, 248p
**SHR-0009694** Available from Aspen Systems Corporation, Publication Department, 1600 Research Boulevard, Rockville, MD 20850.

This book guides persons in health and human services in the use of industrial marketing techniques as a complement to their management and planning processes. Marketing's nine com-



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ponents are identified as the process of selecting and preparing the marketing project, research, the market audit, setting objectives, targeting strategies, special promotional tools, internal adjustments, and evaluation/recycling. Following a brief discussion on how marketing helps a board of directors be responsive to its community, separate chapters address each component. Marketing plans in the human services should focus on only one organizational objective at a time, and a marketing program profile is suggested as a useful tool in this selection process. Research areas covered are the external environment, the organization's internal operations and image, and the competition. Criteria governing the effective selection of the target audience are detailed, as is a hierarchy of marketing strategies ranging from the simple to the complex. The review of promotional tools covers agency brochures, news releases, and newsletters, along with secondary methods such as handbooks and surveys. It also discusses primary channels of communication – advertising, publicity, personal selling, and sales promotion. Guidelines on preparing a formal marketing plan are presented with examples. The final chapters deal with personnel matters, including qualifications of the marketing team, use of outside consultants, and how to convert a public relations specialist into a marketing specialist. Chapter notes, diagrams, tables, and an index are provided.

**94** *Meeting Human Needs: Toward a New Public Philosophy.*
Jack A. Meyer
American Enterprise Inst. for Public Policy Research, Washington, DC.
1982, 469p
**SHR-0009775** Available from American Enterprise Institute for Public Policy Research, 1150 Seventeenth Street NW, Washington, DC 20036.

This volume evaluates the potential of the private sector for delivering a wide range of human services to alleviate social problems. It also assesses the effect of government programs and policies on nongovernmental organizations. The analysis covers trends in government spending and the effect of selected government programs on the incentives for individuals to trade dependency for participation in the labor force. A historical perspective for assessing the changing balance between the public and private sectors supports a greater reliance on local community assistance to those in need as an alternative to nationally imposed solutions. A chapter on business alternatives presents two case studies of companies involved in a range of activities, together with a survey of company-sponsored assistance programs in employment, housing, day care, and other areas. Next, a discussion on the role of organized labor reports on labor-sponsored helping networks around the country. Another chapter, tracing the evolution of successful neighborhood organizations, emphasizes the need for strategies that allow neighborhood residents to participate actively. The third section focuses on components and economics of the private sector, including a macroeconomic and tax policy environment for private sector initiatives and incentives to economic development. The last section examines case studies of private sector initiatives and accompanying public policy analysis in specific problem areas: youth employment, urban transportation, contemporary education, housing for lower income families, containment of health care costs, youth crime prevention, child welfare policy, social service programs, and the potential role of the private sector in monitoring the safety of prescription drugs. Tables, figures, and chapter notes are provided.

**95** *Meeting the Needs of Families of the Psychiatrically Disabled Through Therapy.*
Agnes B. Hatfield; Douglas M. Johnson and Robert F. Fierstein
Apr 82, 22p

**95**

**SHR-0009761** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

The study surveyed 138 family caregivers in 9 States regarding the needs they had in seeking therapy and their perception as to how well their needs were met. Respondents were largely female and mothers, with a median age of 54 years and high educational levels. Findings point to little relationship between what families seek and what they actually receive. Caregivers' top priorities for therapy were reduction of anxiety about the patient, understanding of appropriate patient expectations, education on how to motivate patients and about the nature of mental illness, and assistance during crises. Younger respondents indicated much less concern for learning to motivate patients and to understand their expectations and the nature of mental illness. The less educated group expressed the greatest concern about anxiety and the need to know more about appropriate expectations. Other demographic factors affecting caregiver's priorities are discussed. Study data and 17 reference notes are appended. Author abstract modified. *Presented at the National Conference on Social Welfare, 109th Annual Forum, Boston, Massachusetts, April 25-28, 1982.*

**96** *Meeting the Needs of the Elderly: Home Health Care or Institutionalization.*
J. Dianne Garner and Susan O. Mercer
1982, 9p
**SHR-0009796** Pub. in Health and Social Work v7 n3 p183-191 Aug 82.

The care and treatment of the frail elderly should be part of a broad continuum of service, including both home health care and institutional care. In most instances, home health care should be recognized as an option before placement in a long-term residential health care facility is made. The development or expansion of home health care to meet the frail elderly's needs is justified on several grounds. Home health care may prevent or postpone institutionalization. It may be a way of expanding services and of providing care to a currently underserved or unserved population, and it offers a potentially cost-effective method of delivering health care. However, some of the frail elderly will continue to need institutional care, due to their severe and numerous illnesses. The extent and level of care needed to manage multiple diagnoses, the hardship placed on families in attempting to meet demanding needs that require skilled care, and the numbers presented by demographic projections of elderly likely to need institutional care all support the argument for institutional care. Moreover, institutionalization is more cost-effective than home health care for those in need of ongoing skilled care. Impediments to home health care include Medicare policies inhibiting the use of such services, no uniform definition of home health care, and fragmented services. Impediments to institutional care are Medicare's and Medicaid's policies on payments, the public perception of widespread patient abuse in nursing homes, and poor regulation of long-term care facilities. A total of 28 reference notes are given. Individual reprints of this article are not available from the National Association of Social Workers.

**97** *Method for Evaluating and Improving Goal Consensus for Social Action Programs.*
Michael Smithson
1981, 11p
**SHR-0009817** Pub. in Evaluation and Program Planning v4 no. 3/4 p261-271 1981.

A method is presented for investigating goal priority disagreements in social action programs. The method involves extracting the underlying themes of these disagreements via multidimensional scaling and correlational

techniques. The primary application of the method is to enable the evaluator to determine which aspects of the program are assessable in goal-attainment terms and which are not. Further, the resultant multidimensional maps of goal disagreements may be used as cognitive aids in facilitating discussion among program participants about their disagreements. The method is illustrated by its application to a youth outreach program. The method is to be used mainly by evaluators and program participants during the early phases of program development. It also can give the evaluator sufficient information to decide whether any sort of confirmatory (i.e., goal-achievement oriented) evaluation is feasible, as opposed to purely exploratory investigations. Tabular and graphic data and 13 references are supplied. Goal definitions and instructions for goal priority ratings are appended.

**98** *Model for the Assessment of Community Service Delivery Systems for the Elderly Alcoholic.*
Lenore A. Kola and Jordan I. Kosberg
Case Western Reserve Univ., Cleveland, OH. School of Applied Social Sciences.
May 80, 16p
**SHR-0009739** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

The assessment model addresses the treatment, control, and prevention of alcoholism in the elderly. It addresses itself to three levels of needs constituting a total systems approach to planning: client level needs, agency level needs, and community level needs. Emergency services on a 24-hour basis, inpatient services, outpatient services, intermediate care services, and consultation and education services are all client needs. The client depends upon agencies for services and, therefore, agencies have to be prepared to deliver high standards of care. To ensure that agencies are fulfilling their purposes, they must be individually assessed regarding policy and practice, treatment philosophy and practice, continuity of care, recordkeeping, manpower, knowledge adequacy and training, accessibility of resources, and funding. On the community level, psychological and social factors must be addressed, such as poverty, poor health, and poor housing – and those who work with the elderly must become more educated about symptoms of alcoholism. Finally, the community must make existing health and social systems available to the elderly alcoholic and the alcoholic's family. One table and 21 references are included. *Presented at the 1980 Annual Forum of the National Conference on Social Welfare, Cleveland, Ohio, May 20, 1980.*

**99** *Model Mental Health Service Delivery System for Southeast Asian Refugees.*
Kenji Murase
Pacific Asian Mental Health Research Project, San Francisco, CA.
Apr 82, 20p
**SHR-0009764** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

The paper discusses the medical, mental health, and employment status and needs of Southeast Asian refugees in Orange County, Calif., and describes the proposed services of the Community Resources Opportunity Project (CROP) to meet these needs in the county. Many refugees are subsisting at or near the poverty level and are encountering difficulties in becoming economically self-sufficient. Most of those employed are working in full-time semiskilled or unskilled trainee positions; of these, many still require some form of cash assistance to supplement their incomes. County voluntary agencies estimate that 75 to 80 percent of the newly arriving refugees require bilingual assistance to function on a job. CROP proposes the following services to assist refugees: a community access



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and linkage line to provide a central information, referral, and counseling source; community-based counselors to help refugees in a number of areas; employment training and placement; and health services. The project also intends to design businesses that will not produce revenue but that will train clients to enter job markets. CROP's organizational design is described and illustrated. Eight references are cited. *Paper presented at the 109th Annual Forum of the National Conference on Social Welfare, April 25-28, 1982, Boston, Massachusetts.*

**100** *Myths and Realities of Crisis Intervention.*
Rosemary Creed Lukton
1982, 10p
**SHR-0009828** Pub. in Social Casework v63 n5 p276-285 May 82.

Crisis situations can be fully understood only by considering the person-in-crisis situation as an organic whole. Although many mental health workers have repudiated the medical model of intervention, they still treat the hazardous situation as if it were a single causative factor and categorize and label clients. Crisis intervention can be directed toward clients with a borderline personality structure, as well as to well-functioning people. The dominant type of intervention is the generic approach, which focuses on crisis stemming from a hazardous event rather than from the psychodynamics of the individual in crisis. Further refinements are needed in this intervention approach. The notion of a time limit for intervention is linked to the concepts of generic stages of crisis intervention, as is the association with a crisis state of an identifiable hazardous event. Although crises are designated as maturational or situational and the coping tasks associated with these crises are supposedly preordained in sequence, these designations are not infallible, and much remains to be learned about what helps people. Alternative ways of refining crisis interventions include using precipitating stress as a focus for intervention, doing additional research on the problems that generate crises, learning from the client which tasks are best to use, and fostering support networks. Case comparison, a good research method, recognizes the novelty of each case and distinguishes observations that fit existing categories from those that do not. The paper discusses rape as an illustration of a generic crisis, loss and mourning as situational crises, and maturational crises. A total of 43 footnotes are supplied. *Based on a paper presented at the Conference on Crisis Intervention, Albany, New York, May 1981.*

**101** *New York State/National Institute of Mental Health Community Support Project Demonstration Site Evaluation: Distinguishing Characteristics of Model Community Support Systems.*
Peter B. Lannon
New York State Office of Mental Health, Albany. Community Support Project.
National Inst. of Mental Health, Washington, DC.
Mar 80, 11p
**SHR-0009685** Available from New York State Office of Mental Health, 44 Holland Avenue, Albany, NY 12229.

Three demonstration sites in New York State that applied the principles of model Community Support Systems (CSS) in the care of the chronically mentally ill were compared to two other, more traditional, treatment environments. The analysis focused on how the model sites coordinated the system's components, provided a comprehensive and integrated range of services to accommodate diverse client needs, provided services in the least restrictive setting, and made services of both the mental health system and the community available and accessible to clients. An instrument was developed to assess client demographic characteristics, clinical history, basic living and social skills, and behavioral and somatic prob-

lems. It also assessed service utilization and case manager involvement in service delivery for 42 generic services and provided information on the use of the 10 services within the CSS. The number of chronically mentally ill clients surveyed in the baseline survey was 624 – 423 from the demonstration sites and 201 from the comparison sites. The results indicated enhanced program development and service utilization for the chronically mentally ill at the demonstration sites in the areas of crisis assistance, assistance in applying for income and medical benefits, prevocational training and counseling, social activities, medical and mental health services, supportive assistance and consultation to the community, transportation, and identification and outreach. There was also greater and more consistent involvement of case managers in the delivery of services at the demonstration sites. Demonstration sites were less reliant on psychiatric centers for service delivery and made greater use of generic service providers in the community. The report concludes that the data support the declaration that the model CSS services are well integrated, comprehensive, community-based, less restrictive, available, and accessible. Footnotes and tabular data are given.

**102** *No Access to Law: Alternatives to the American Judicial System.*
Laura Nader
Center for the Study of Responsive Law, Washington, DC.
Carnegie Corp. of New York.
1980, 540p
**SHR-0009758** Available from Academic Press, Inc., 111 Fifth Avenue, New York, NY 10003.

This volume presents essays and research studies on the nonjudicial mechanisms for handling grievances by businesses, government organizations, volunteer organizations, and other organizations. The studies analyzed the consequences of the current system of complaint handling to determine which mechanisms are effective and which are ineffective. Three hundred consumer complaint letters sent to Ralph Nader were analyzed to determine problems, the methods of communicating dissatisfaction, and remedies sought. The analysis focused on 100 letters each in the categories of food, medical, and appliance problems. One case study was conducted to determine the strategies and choices that lead consumers to complain to third-party agents to remedy a problem. Additional studies focus on the handling of complaints by trade associations, the operation of the Better Business Bureau system, and the handling of complaints by six major department stores in the San Francisco Bay area. Other studies examine the complaint-management process of the California Department of Insurance, the handling of citizen complaints by a Philadelphia congressman, and three organizations that process complaints in a low-income neighborhood in Washington, D.C. Also discussed are a voluntary consumer organization's efforts in San Francisco, the procedure for handling complaints in one labor union, and the action lines operated by the mass media. Tables, chapter notes and references, an author index, and a subject index are included.

**103** *Objectives, Standards, and Evaluation in Long-Term Care.*
Francis G. Caro
1981, 22p
**SHR-0009738** Pub. in Home Health Care Services Quarterly v2 n1 p5-26 Spring 1981.

This article critiques evaluation objectives of long-term care programs and suggests that provision of adequate solutions to clients' problems in daily living be used as a quality measure. To define such criteria, the quality of daily circumstances of the functionally disabled would have to be systematically described. Accountable objectives based on maintaining the functionally disabled are needed because the conventional goals of improved health or functioning capacity cannot be used to measure

quality of service to patients whose condition precludes improvement and rehabilitation. Objective descriptions of patients' life circumstances should include factors relating to shelter and facilities, eating patterns, personal care patterns, clothing, activity and self-expression, health maintenance, mobility, and options for choice in daily routine and personal matters. Citizen panels could establish quality of circumstances standards at a community level, reflecting the general community lifestyle and culture in a manner similar to the functioning of local school boards. The standards articulated by these groups should reflect a reasonable balance between ameliorating the lifestyle of the functionally disabled and limiting public long-term care expenditures. Furthermore, these panels should also define standards for family participation in the support of their disabled members, setting forth the appropriate division of labor between families and organized services. Dimensions to be considered here are the financial, lifestyle, and health impacts upon caretakers who choose to maintain their disabled at home. A total of 11 references are given. *Reprinted from Family Care of the Elderly, by Frankfather, Smith, and Caro, 1981.*

**104** *Permanency Planning: In the Best Interests of the Child.*
Frank C. Woolley
Apr 82, 18p
**SHR-0009755** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

This paper cites research questioning the assumptions underlying permanency planning, in which efforts are made to move children out of foster care and into permanent placements in their natural families or adoptive families as soon as possible. Permanency planning has developed into a major movement in the child welfare field. The movement is based primarily on inferential evidence that children would be better adjusted because of greater continuity of care, the avoidance of foster care's negative aspects, and the positive benefits of adoption. However, the literature does not support the idea that children need continuity in their relationships with parent figures to maximize their psychosocial development. Moreover, studies of the adoption of young children are not directly relevant to the adoption of older children who have spent significant parts of their early childhoods in their own families. Moreover, the research indicates that permanency planning results in an increase in the number of adoptions, but not in the numbers of children who can return to their parents. Some research indicates that contact with the biological parent is important for a child's adjustment and that adoption may, therefore, not be the most appropriate choice for older children. Moreover, the portrayal of foster care as involving continuous drift among placements is inaccurate. As was the case with job programs and the juvenile court, governmental programs intended to benefit children may have negative consequences. Although permanency planning is politically attractive due to its lower costs than the foster care system, its benefits for children have yet to be proved. Further research is needed. A total of 32 footnotes are provided.

**105** *Planner's Guide to the Medicare Statistical System.*
Alpha Center for Health Planning, Bethesda, MD.
Health Care Financing Administration, Washington, DC.
American Health Planning Association, Washington, DC.
Oct 81, 172p
**SHR-0009651** Available from American Health Planning Association, 1601 Connecticut Avenue NW, Suite 700, Washington, DC 20009.

This document provides information on the Medicare Statistical System (MSS) to enable health care planners to make appropriate and effective use of its data. The MSS is derived

from ongoing data processing steps required to administer the Medicare insurance program and is composed of three sets of files – enrollment, certified providers, and claims. The guide first describes each major file and the types of data elements it contains. The next section focuses on MSS outputs, particularly data developed for health planning agencies. Examples are given that describe actual uses of MSS data for planning purposes, such as establishing logical structures, estimating baseline status, estimating trends, and informing the public or legislators about the use of public funds for health care. Research uses of MSS data are reported, including development of a case-mix index for hospitals and a cost-effectiveness study of homemaker services for Medicare eligible people. The advantages and disadvantages of MSS data for planning uses are summarized. A survey of planners indicated that a high value has been placed on enrollment data while relatively low value has been given to a set of tables derived from a Medicare Provider Analysis and Review (MEDPAR) file. Finally, some potential uses of MSS data are discussed. Footnotes, a glossary of terms and acronyms, and an index are provided. The appendices contain a description of the Medicare program, a monograph on the Medicare data system, two special MSS reports prepared for health planners, and unpublished tables.

**106** *Pregnant Adolescents: Cost-Benefit Options.*
Rhoda Abel; Janet L. Jackson; Edith Fein; Elizabeth L. Al-Sagaf and Dawn Shuster
1982, 5p
**SHR-0009827** Pub. in Social Casework v63 n5 p286-290 May 82.

A cost-benefit options approach for working with pregnant teenagers developed by Child and Family Services (CFS) of Hartford, Conn., emphasizes the interruption of the cycle of intergenerational conflict of which the pregnancy is only a symptom. The treatment model involves the entire family as a decisionmaking unit and focuses on the cost-accounting each individual has to go through as part of the process. The CFS treatment approach requires that plans for keeping or giving up the baby not be emphasized; a family is encouraged to make its own decisions. Information about all of the available options is supplied to the family, which is also helped with its cost accounting. The task involves accurate information about abortion, contraception, financial and medical assistance, housing, maternity homes, clinics or physicians for prenatal care, and legal matters. The caseworker also explores and supports any existing economic opportunities for the girl, so that she may more clearly understand the risks she is likely to face in having an unplanned child. The worker encourages realistically high expectations for the young woman's future education or job or vocational training. Guidelines encompassing the treatment approach are delineated, and a case example illustrates the treatment approach. A total of 13 footnotes are provided.

**107** *Preliminary Short Term Evaluation of the Basic Grants Program of the Administration for Native Americans.*
Aurora Associates, Inc., Washington, DC.
Office of the Assistant Secretary for Planning and Evaluation (DHHS), Washington, DC. Office of Evaluation and Technical Analysis.
Westat, Inc., Rockville, MD.
1 Mar 82, 74p
**SHR-0009723** Available NTIS PC$09.00/MF$4.00

The evaluation focused on the Administration for Native Americans (ANA) grant program through fiscal year 1981, emphasizing ANA's Social and Economic Development Strategies (SEDS) program fostering local control and decisionmaking to improve service delivery and enhance economic progress. The 11 grantees visited (reservations, Indian centers, and tribal

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organizations) indicated that ANA provides direct grant funds with which to implement strategies addressing long-term problems. These funds are used for staff support, management, fiscal planning, etc. Most ANA-supported staff accomplishments have involved strengthening management and planning functions, formulating plans for natural resource development, and carrying out needs assessments and feasibility studies. Individual grantees plan to renegotiate mineral leases, use minority hiring and contracting requirements to increase employment, and continue operating a business development office. ANA should use this information in making grant awards. Graphs and tables present study results, and appendices include additional data and synopses of site visit records. Author abstract modified.

**108** *Productivity in Human Services: An Overview.*
Edward C. Baumheier
1982, 14p
**SHR-0009713** Pub. in Jnl. of Health and Human Resources Administration v4 n4 p451-464 Spring 1982.

Productivity results from applying the basic tenets of public administration and modern technology to achieve the optimum in program results. A preoccupation with means to the exclusion of ends can result in doing the wrong things more efficiently. Thus, both policy and management considerations are important. Productivity improvement programs involve both measurement and evaluation of programmatic efforts as well as the application of appropriate techniques to increase efficiency. Clarity of objectives and the appropriate technology for achieving them are essential to increased productivity. Although progress has been made in a few instances and some technology transfer applications are available, few general, tried and tested approaches to productivity improvement can be recommended to aid administrators of human service programs. One approach that holds some promise for improved efficiency is that of work scheduling to achieve a better balance of the workload of employees versus the demand for their services. Another is the quality circle, applied in Japan, which involves a regular meeting of a team of employees to identify, analyze, and propose solutions to problems in their areas of expertise. Five notes and 11 references are supplied. *Revised version of a paper prepared for a panel on Productivity Improvement in Human Services, Section on Human Resources Administration, ASPA annual conference, Detroit, Michigan, April 12-15, 1981.*

**109** *Productivity Sharing Programs: Can They Contribute to Productivity Improvement.*
General Accounting Office, Washington, DC.
3 Mar 81, 33p
**SHR-0009662** Available from U.S. General Accounting Office, Document Handling and Information Services Facility, PO Box 6015, Gaithersburg, MD 20760.

Officials of 54 business firms, 36 of which had productivity sharing plans, were interviewed to determine how productivity sharing plans operate, the benefits that result from these plans, and potential long-term increases in productivity from these plans. The study was part of a congressionally requested review of efforts to focus on productivity as a means to reduce inflation. Productivity sharing plans are systems by which a bonus or percentage of profits is paid to a group of employees based on overall performance. Productivity sharing plans are designed to measure the productivity of a plant or firm and to share the benefits of productivity gains with all participating employees. The plans use either dollars or hours as the unit for measuring work. Among factors that vary in these plans are the number and type of employees covered, the role of consultants in designing a plan, the conditions for bonus payments, and the amount of assurance em-

ployees receive that the payments are equitable. Six firms found that their productivity sharing plans were unsuccessful for such reasons as financial difficulties and lack of management commitment. Although productivity sharing plans produce many benefits, they should not be viewed as a panacea. Officials of firms that have adopted such plans and other knowledgeable sources recommend that advice be sought from firms that have adopted successful plans and that a vote be taken on implementing the chosen plan. Additional recommendations, tables, and an appendix presenting a profile of the interviewed firms are supplied.

**110** *Project S.A.V.E.: A Volunteer Program to Combat Alcoholism.*
Harold L. Mowles
1982, 5p
**SHR-0009795** Pub. in Health and Social Work v7 n3 p215-219 Aug 82.

Project SAVE (Serve Alcoholic Veterans in Emergency), helps alcoholics through the admission process of a Veterans Administration hospital in southern California and into treatment. Project SAVE's volunteers are recovering alcoholics (having abstained from alcohol and other drugs for at least 45 days) who are military veterans. Nearly all are male. Project SAVE follows a standard procedure when it receives a call for help from the staff of the hospital's emergency room or walk-in clinic. All calls are received by a dispatcher who records pertinent information and sends a two-person team to see the client. The team members discuss with the client their own difficulties in asking for help to encourage the client to talk. Regardless of the time, the team members remain with the client until admission to the Alcoholic Treatment Unit is completed. The project has benefited the veterans in treatment, the hospital, the community, and the alcoholics who serve as volunteers. As of August 1981, SAVE had provided 17,000 hours of service to more than 1,800 problem drinkers. About 70 percent of the individuals seen by SAVE enrolled in alcoholism treatment at the hospital. SAVE also acts as a liaison between the hospital and various alcoholism treatment services in the community. The volunteers gain enhanced self-esteem and renewed motivation to remain sober. Individual reprints of this article are not available from the National Association of Social Workers.

**111** *Protective Services for Adults: A Guide to Exemplary Practice in States Providing Protective Services to Adults in OHDS Programs.*
James J. Burr
Administration on Aging, Washington, DC.
1982, 197p
**SHR-0009698** Available NTIS PC$16.50/MF$4.00

This monograph reports on States' efforts to define and set standards for protective services for adults, including the aged, in public social service programs. Ways that different States define protective services are reviewed, as are the purposes of such programs and client characteristics. Based on materials contributed by 40 States, the report focuses on the scope of protective services and State standards and policies governing their provision. Areas covered include the intake process, client's rights, a relative's responsibility for the client, assessment processes, fees, and placement. Other standards address the individual service plan, delivery strategies, and complaint investigation and reporting. Social and legal interventions used by States in providing protection to adults with varied problems and needs are described. Individual areas reviewed are types of appropriate social interventions, emergency services, costs, and the maintenance of records to determine the volume of abuse or neglect as a basis for subsequent action. The final chapter deals with the following issues in protective services: the place of such services in the State's overall program, the use of agency staff as client guard-

ians, the impact of this service on clients' rights, the consequences of protective services, and service integration. Individual States' experiences are cited throughout the document. Footnotes and about 30 references are included. The appendices contain tables on States' protective services and a directory of State offices responsible for protective services.

**112** *Public Policies and Long Term Care for the Elderly: A Multibillion Dollar Dilemma.*
Carroll L. Estes; Philip R. Lee; Charlene Harrington; Lenore Gerard and Mary Kreger
California Univ., San Francisco. Aging Health Policy Center.
Jan 81, 61p
**SHR-0009666** Available from Aging Health Policy Center, University of California, San Francisco, CA 94143.

This paper reviews issues and policy choices related to long-term care for California's elderly population. The central issues are the methods of planning and providing care under increasing fiscal constraints, the mix of State and Federal policies for both institutional and noninstitutional care, program administration and financing, and control of program costs. Factors that must be considered in planning for care services include current public policies, needs of the elderly, service availability, demand for services, and costs of services. The available policy choices are sharply limited by Federal law, particularly under the Supplemental Security Income, Medicare, Medicaid, and social services law. The first step in planning for California's elderly should be the collection of adequate data on such subjects as the cost and length of stays in health care institutions, senior citizens' disabilities, and other needs. Housing policy for the elderly is also needed to supplement the current mix of income maintenance, health, and social services policies in California. The State's supplement to Supplemental Security Income should continue to be used as the foundation for all other State policies affecting long-term care. The MediCal program should change to a less restrictive policy regarding home care and community-based care. Additional recommendations, 5 tables, and 61 reference notes are supplied. *Working Paper no. 12.*

**113** *Public School Programs for Adolescent Pregnancy and Parenthood: An Assessment.*
Gail L. Zellman
National Inst. of Education, Washington, DC.
1981, 7p
**SHR-0009724** Pub. in Family Planning Perspectives v14 n1 p15-21 Jan/Feb 1982.

The article describes school pregnancy programs in terms of program initiation, planning and implementation, funding and costs, classes and services offered, and strengths/weaknesses. It studied 12 programs for pregnant teenagers and teenage mothers in 11 school districts across the country. The programs offered curriculum or noncurriculum programs for these youngsters or had supplementary curriculum programs. Budget limitations and negative community attitudes limit the growth of these programs; support from high-level administrators and special interest groups generally get these programs off the ground. However, Federal and State support for special programs actually keeps program costs lower than those for regular classes, a finding that most administrators are unaware of. Curriculum programs separate from the regular school generally provide a wider range of services than the other programs but suffer from poor academic quality. The programs' academic weaknesses are exacerbated by a lack of appropriate texts, supplies, and equipment. They vary widely in staff qualifications and enthusiasm, staff morale, degree of coordination with community agencies, and the service quality. They would be helped by continued financial support, bet-

ter cooperation within school districts, and greater initial leadership. Footnotes, tables, and 11 references are supplied. *Adapted from The Response of the Schools to Teenage Pregnancy and Parenthood, 1981, by the author.*

**114** *Quality Assurance in Dentistry. A Study of the State of the Art.*
Susan Kahn Stern
1979, 7p
**SHR-0009810** Pub. in Quality Review Bulletin v5 n9 p25-31 Sep 79.

The American Dental Association's state-of-the-art study of dental quality assurance sought to describe existing systems of quality assurance programs that conform to the needs of dentistry and professional requirements for ambulatory care review. A total of 48 review programs were identified and categorized by the principal data source used: clinical examination, record review, profile analysis, or any combination. A lengthy questionnaire and site visit were conducted on 11 systems. A quality assurance model was used for assessing the systems across each characteristic (i.e., goal of the system, completeness of the evaluation, activity level, replicability in other dental settings, and configuration of dentist/nondentist participation). Project findings revealed that none of the 11 programs studied could be considered ideal. No one approach to review – clinical examination, record review, or profile analysis – had been tested sufficiently to serve as a model. However, profile analysis was chosen as the preferable method to be given priority in developing dental quality assurance systems because it is based on existing data collected routinely in the office, requires no travel by dentists, and is the least disruptive. Tabular data and 6 references are given. *Parts of this article were adapted from Quality Assurance in Dentistry: Executive Summary, which appeared in three parts in the January, February, and March 1979 issues of the Journal of the American Dental Association, vol. 98.*

**115** *Quality of Life: Evaluating the Community Support Program.*
New York State Office of Mental Health, Albany. Community Support Project.
National Inst. of Mental Health, Rockville, MD.
Jun 80, 109p
**SHR-0009688** Available from New York State Office of Mental Health, 44 Holland Avenue, Albany, NY 12229.

Community support program (CSP) evaluators from several State, local, and Federal CSP's discuss issues concerning the concept and measurement of the quality of life of the chronically mentally ill. They explore the CSP's need for evaluative information, the appropriateness of quality of life as an evaluation concept for the CSP, and the framework from which to proceed in conducting the evaluation. The evaluators determine that studying the quality of life as a measure of client outcome is an appropriate evaluation component and consistent with the Community Support Services' major goals and intended impact. The National Institute of Mental Health (NIMH) should support and encourage efforts to incorporate quality of life measures in future evaluations. CSP staff also recommend adoption of the Oregon Theory of Quality of Life on the conceptual framework for evaluation. They suggest that NIMH ensure that outcomes and program objectives are specified and appropriate, and that objectives and criteria regarding the system and service implementation and client change and outcome be specified. NIMH should also continue supporting quality of life development through grants or cooperative agreements or a combination of grants and contracts. The report includes footnotes, about 70 references, and an annotated bibliography with approximately 90 citations.

**116** *Quota Systems and the Employment of the Handicapped: Experiences in Three Countries.*
Linda Chadderdon and William Frey



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Michigan State Univ., East Lansing. University Center for International Rehabilitation.
National Inst. of Handicapped Research, Washington, DC.
1982, 76p
**SHR-0009695** Available from University Centers for International Rehabilitation, Publications, 513 Erickson Hall, Michigan State University, East Lansing, MI 48824-1034.

This book studies quota systems requiring that public and private employers of a certain size employ a given number of handicapped persons in the Federal Republic of Germany, Great Britain, and Japan. Following a review of the disadvantages and benefits of a quota system, the report traces the history of such legislation, which emerged in several European countries after many young men returned from World War I with severe disabilities. The effectiveness of this approach remains controversial, but an increasing number of countries are considering compulsory employment of the handicapped. The quota systems of the Federal Republic of Germany, Great Britain, and Japan are described in detail, since these countries have considerable experience with the method and have experimented with various approaches. Areas covered include the formulas for calculating the quota, eligibility, incentives for employers to comply with the laws, and an evaluation of the system's performance and costs. Factors affecting the quota system's operations are examined, such as labor market conditions, structure of rehabilitation services, attitudes of employers and coworkers, and the influence of cultural traditions. A general appraisal comments that Great Britain's system has many loopholes and flaws, but may not be disbanded because of pressures from organizations advocating for the disabled. Both the West German and Japanese experiences, however, show that properly planned and administered quota systems can promote the employment of handicapped persons. Tables, footnotes, and 42 references are provided. The appendix contains provisions of typical employment promotion programs for the handicapped.

**117** *Reaching Into Board and Care Homes Through Outreach.*
Hannah Handman and Renee Feiger
1982, 6p
**SHR-0009814** Pub. in Aging n329/330 p8-13 Jul/Aug 82.

The Los Angeles Freda Mohr Multiservice Center developed a successful program to extend its counseling and support services to residents of board and care homes. The Center's outreach program helps meet the seniors' needs by providing residents with daily mental and physical stimulation that encourages socialization and a sense of community within the homes. Outreach staff work in pairs of two, with each team offering regular programming in two board and care homes each day and returning to the Center for group supervision. The programming includes group discussions, current events, exercises, entertainment, arts, crafts, music, games, and outings. Additional volunteers are used to provide special entertainment, educational, health, or art programs. Dance/movement therapists, drama specialists, and poets visit regularly. The outreach effort has significantly improved the seniors' self-esteem, well being, and sense of community. In addition, the outreach program has positively influenced board and care home owners and staff, individual volunteers and groups, and the general community. Photographs are provided.

**118** *Report on a State-Wide Community Mental Health Center Outcome Study.*
Gary B. Cox; Timothy R. Brown; Paul D. Peterson and Maureen M. Rowe
National Inst. of Mental Health, Rockville, MD.
Washington State Dept. of Social and Health Services, Olympia.
1982, 16p

**SHR-0009691** Pub. in Community Mental Health Jnl. v18 n2 p135-150 Summer 1982.

The Washington State mental outcome study involved two clients' samples – one assessed both at the time of admission and again 90 days later and the other (a random cross section of the caseload) assessed only once. It developed a special assessment instrument heavily oriented toward social adjustment but also including some concern for traditional psychiatric symptoms and daily living activities. Interviewers collected demographic data and administered the questionnaires. Results show highly significant changes between pretreatment and posttreatment interviews, although these changes cannot be attributed to the treatment programs since there was no control group. The data have been used by State mental health administrators in presentations to legislatures and community groups. Other models of statewide mental health outcome, such as the Oregon approach (Brodsky and Bigelow, 1980) and that proposed by Schainblatt and Hatry, may be useful to compare with the Washington model. Tables and 17 references are supplied. Author abstract modified.

**119** *Respite Care: An Emerging Family Support Service.*

Judith W. Meltzer
Center for the Study of Social Policy, Washington, DC.
Administration on Aging, Washington, DC.
National Conference on Social Welfare, Washington, DC.
Jun 82, 26p
**SHR-0009655** Available from National Conference on Social Welfare, 1730 M Street NW, Washington, DC 20036.

This paper assesses the current state of knowledge about respite care services, which offer relief to spouses or relatives caring for a dependent or disabled person. Research studies have revealed that most families want to care for their relatives and make decisions about institutionalizing the elderly and disabled very reluctantly. Respite care is one component in family support services that can alleviate these caregivers' stresses and prevent costly institutionalization. A review of respite care programs in 13 States covers the types of services offered, eligibility, providers, financing, and administration. Another section describes the few existing evaluations of respite care – a report of a small research program in California and a study of institutional respite care in six facilities in New York State. The California researchers concluded that the respite project for older wives caring for disabled husbands provided an enormously important resource for the involved families for a relatively small investment. The New York evaluation found that institutional respite care service could be developed with a moderate amount of regulatory conflict and that modification of some regulations could provide strong incentives to providers to offer respite. Noting that considerable evaluative research is needed on respite care, the paper recommends that respite be considered only as part of a family support system and suggests extending eligibility for respite programs beyond State Medicaid levels. Tables and 10 footnotes are included.

**120** *Role of the Social Worker in a Burn Unit.*

Norma Ferro; Helen Jaffe and Carolyn Kosowsky
1979, 5p
**SHR-0009812** Pub. in Quality Review Bulletin v5 n7 p21-25 Jul 79.

A social worker is probably more indispensable in a burn unit than in any other unit of a general acute care hospital. The social worker on the burn unit team of Cook County Hospital in Chicago, Ill., must face both the stress inherent in working on a team and the stress generated by the crisis nature of the service. Because both

adults and children are treated in the burn unit, the social worker must be adept at working with all ages. Social work tasks on the burn unit include performing a psychosocial evaluation of all patients admitted to the unit and providing long-term support for the patient and family during hospitalization and after discharge. The psychosocial evaluation includes data about medical, social, and economic functioning and the specific problems presented by the patient. The evaluation includes a delineation of treatment goals. The initial evaluation is followed by long-term social service involvement with the patient and patient's family. The social worker can provide practical support in facilitating health education of patients and families by reinforcing the instructions they have received from other members of the burn unit. The worker provides emotional support by listening to the patient discuss problems. The goal is to restore the patient's physical, emotional, and social functioning to the greatest degree possible. The social worker's tasks in working with the dying patient and with cases of child abuse in the burn unit are noted. The process of peer review and evaluation is also mentioned. A sample social service record is included.

**121** *Service Coordination/Delivery Dichotomy: A Critical Issue to Address in Reforming the Long Term Care System.*
Dennis L. Kodner and Eli S. Feldman
1982, 10p
**SHR-0009807** Pub. in Home Health Care Services Quarterly v3 n1 p59-68 Spring 1982.

The Federal Government has sought to identify the ideal case management (CM) model which can both control service expenditures and ensure appropriate care. Of the two CM approaches–"brokering" and "consolidation"–the former has been preferred because of its autonomy from existing delivery systems, which enables identification of system problems, advocacy of system reform, and response to government policy direction as well as conflict-of-interest-free client service plans based on real needs rather than available services. Systematic and meaningful analyses of the costs, benefits, and drawbacks of either model, however, have not been produced. Consolidated CM, where one responsible provider organization at the local level handles intake, assessment, case coordination, service provision, and quality control, can be developed to address the legitimate concerns of government and consumers for accountable, appropriate, high-quality, cost-effective care. A demonstration of this approach, the Social/Health Maintenance Organization (S/HMO) combines the organizational effectiveness of health maintenance organizations and various community-based long-term care projects by serving a voluntary enrolled population through prepaid capitation. Its advantages are limiting program expenditures, permitting flexible service patterns, incorporating case coordination, and emphasizing preventive and nonmedical supports. S/HMO's are expected to substitute in-home and community-based care for hospital and nursing home care, guarantee access to needed services, provide greater continuity of care, and forge strong agency commitments to maintaining the elderly at the highest possible level of function. A total of 17 references are given. *Based on a presentation given at the 109th Annual Meeting of the American Public Health Association in Los Angeles, CA in November, 1981.*

**122** *Shared-Ride Taxi Services as Community Public Transit.*
Roger F. Teal; Gordon J. Fielding; Genevieve Giuliano; James V. Marks and Richard E. Goodhue
California Univ., Irvine. Inst. of Transportation Studies.
Urban Mass Transportation Administration, Washington, DC. Univ. Research and Training Div.
Mar 80, 242p
**SHR-0020570** Available NTIS PC$19.50/MF$4.00

Based on California's experiences with subsidized shared-ride taxi (SRT) services as a demand-responsive transit (DRT) system, this report presents case reviews of SRT implementation, analyzes issues associated with developing SRT, and evaluates its performance. These systems have become the predominant form of public demand-responsive transportation in California, with 29 in operation as of mid-1979. Case studies examine the development and performance of subsidized SRT systems in different localities and under the sponsorship of different types of public agencies. One case on a taxi-based system for the handicapped and elderly is included. The analysis of institutional issues connected with SRT focuses on three categories: reasons why public agencies and taxis become involved and the form their involvement takes; service organization matters such as contractual arrangements and their effects on costs and performance; and consequences for taxi firms of becoming public transit providers, including legal implications, labor-management relations, and the contract's impact on profitability. An evaluation of SRT performance in terms of cost efficiency and effectiveness indicates that most sponsors are satisfied with the taxi system and that SRT contracts have given taxi firms an infusion of needed revenue. As production costs inevitably rise, however, this form of DRT may become too expensive for sponsors if cost effectiveness cannot be improved through productivity advances. Footnotes and tables are included.

**123** *Similarities and Differences Between an Urban and a Rural Hospital Based Home Care Program.*
Daniel E. Rodell and Judith H. Jameson
Veterans Administration Medical Center, Little Rock, AR. Ambulatory Care Information System.
1980, 9p
**SHR-0009707** Pub. in Home Health Care Services Quarterly v2 n4 p29-37 Winter 1981.

The 3-month study examined 116 patients assigned to an urban or rural hospital based home care program (HBHC) to determine whether services provided by an urban-based HBHC team could be extended by a rural-based team to a similar but rural, chronically ill patient population. It gathered variables reflecting medical and socioeconomic patient characteristics and level of services provided to test for significant differences between the two programs. Two-tailed difference of group means t-tests revealed that only the number of medications and supplies dispensed attained significance; patients in the urban program received more than their rural counterparts, a result probably due to the greater proximity of the program physician to the urban-based team. Thus, it may be possible to maintain severely disabled patients in their own homes in rural as well as urban settings. Tables present study results. Seven references and definitions of levels of disability are appended. Author abstract modified.

**124** *Social Models of Long-Term Care.*
Marie-Louise Ansak
On Lok Senior Health Services, San Francisco, CA.
Jun 81, 7p
**SHR-0009763** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

On Lok Health Services, a nonprofit, community-based organization serving functionally disabled older adults in San Francisco, Calif., operates a Community Care Organization for Dependent Adults (CCODA). The CCODA differs from traditional long-term care responses in that On Lok assumes responsibility for providing all services needed by clients. Social and medical services are integrated into a single health program and are delivered by the same professionals planning them. All services are funded through a single source. The program hopes to institutionalize a prospective, capitation reimbursement with the assumption of risk

as a financial incentive to control costs. On Lok has an extensive evaluation component focusing on costs, quality of care, health service patterns, etc. Program costs are lower than the Medicaid reimbursement rate for skilled nursing home care in the area, as well as Medicare and private care costs. The CCODA appears to be acceptable to most elderly clients. *Presentation at the National Conference on Social Welfare, San Francisco, California, June 7-10, 1981.*

**125** *Social Service Planning Cycles: Ritualism or Rationalism.*
Neil Gilbert; Harry Specht and David A. Lindeman
Administration on Aging, Washington, DC.
California Univ., Berkeley. Committee on Research.
1981, 15p
**SHR-0009751** Pub. in Social Service Review v55 n3 p419-433 Sep 81.

This study examined the effects of increased planning effort on the allocation and reallocation of funds via the 1974 Title XX Amendments to the Social Security Act. The amendments set in motion a major planning effort regarding the allocation of Federal funds previously financed under several categorical programs. Study information was gathered through an analysis of all annual service plans for the 50 States and the District of Columbia for each of the 5 fiscal years from 1975 to 1980. Both national and State trends in Title XX allocations over the 5-year period were assessed. The degree of change from year to year was found to be rather small. In addition, Title XX funds are becoming less flexible block grants. Moreover, it currently costs about $1 for planning to reallocate $7 worth of Title XX services. Federal officials have recently recognized the shortcomings of the 1-year planning cycle. Although the 1-year cycle has certain advantages, such as its coordination with the Federal budget cycle, the idea of extended planning cycles for the social service systems covered by Title XX has considerable merit. The need for responsiveness must be balanced against the length of time required for a deliberate, efficient, well-informed planning process. A total of 16 reference notes are included. *Presented at the Sino-American Conference on Social Welfare Development in the 1980s, Taipei, Republic of China, December 28-31, 1980.*

**126** *Social Worker in an Adult Day Service Program.*
Patricia Stoddard
1982, 6p
**SHR-0009753** Pub. in Nursing Homes v31 n3 p32-36, 38 May/Jun 82.

The social worker's role in an adult day service program is described based on the day services program of the Benedictine Health Center on the campus of the College of St. Scholastica in Duluth, Minn. Adult day care typically includes recreation, nutrition, health care, information and referral, counseling, and transportation services. More than 600 day care programs are operating in the United States, and more are needed. Social work is an important feature of the day care program at the Benedictine Health Center. The social worker has responsibility for preadmission planning and intake, initial planning, care planning, information and referral to community services, counseling, therapy, the scheduling of care conferences, and participant advocacy. Other shared or joint duties include group work, written contacts with families, crisis intervention, social interactions with participants, and substitution for the director of day services. The social worker for day services confers with the director of the total social services department but reports directly to the director of activities and day services. The role of the social worker at the Benedictine Health Center day program could serve as a model for the social worker role in a day services program operating within a residential nursing facility. A

detailed description of the social worker's specific responsibilities and 23 references are provided.

**127** *Special Paratransit Service for Elderly and Handicapped Persons: Decision Manual for System Design.*
Ned Einstein
Transportation Alternatives, Inc., Van Nuys, CA.
Urban Mass Transportation Administration, Washington, DC. Office of Planning Assistance.
National Inst. for Advanced Studies, Washington, DC.
Oct 81, 326p
**SHR-0009661** Available from United States Department of Transportation, Technology Sharing I/30, 400 Seventh Street SW, Washington, DC 20590.

This manual is designed as a reference document to assist local communities in making decisions concerning the planning, design, and operation of demand-responsive transportation systems for elderly and handicapped persons – commonly known as special paratransit. This volume and others in the series are the result of a 2-year examination of 30 systems in 18 U.S. cities by the Urban Mass Transportation Administration. Part I deals with broad policy choices regarding who will be allowed to use the system, where and when they will be allowed to go, and whether they will be charged for the service. Part II focuses on specific decisions that define the system's dimensions, such as criteria for eligibility, types of vehicles to be purchased, operating hours, drivers' wages and benefits, and the fare structure. Decisions related to systems operations are addressed in Part III, beginning with organizational relationships. Other areas considered include scheduling and dispatching, reservation procedures, training, maintenance, insurance, client referral, and marketing. Each chapter first presents an overview of the subject matter and options for resolving the basic decisions. It then outlines the impacts of these decisions on every other decisionmaking area. Tables and footnotes are provided. Descriptions of Federal funding programs for paratransit systems and information on paratransit vehicles and equipment are appended. *See also related document, SHR-0009528.*

**128** *Staff Projections of Program Need Within a Continuum of Residential Care.*
J. W. Jacobson
New York State Office of Mental Retardation and Developmental Disabilities, Albany. Bureau of Program Research and Planning.
Aug 82, 53p
**SHR-0009771** Available from Bureau of Program Research and Planning, New York State Office of Mental Retardation and Developmental Disabilities, 44 Holland Avenue, Albany, NY 12229.

This report summarizes information about the prospective residential program needs for over 45,000 persons with developmental disabilities in New York State. Several methods, including case-specific staff projections, a level of care model, Developmental Disability Information System (DDIS) analysis, and county projections of program need, are used to anticipate program needs. Regardless of method, analyses of program needs indicated decreased reliance on institutional or congregate care programs and increased reliance on community living alternatives. Specifically, both staff and DDIS projections showed that more than a two fold increase in community residences is needed. Staff projections generally were congruent with county projections, but differed from DDIS-based estimates. The staff were more likely to project that a person should remain in the current setting for the immediate future, particularly if this was a community living alternative. The findings also suggested that changes

in the number of spaces available in each program type were desirable, but major alterations in service delivery patterns were not needed. Differences between staff projections and other methods are discussed. Tables, charts, and about 40 references are provided. Summary statistics for the DDIS as of July 1981 and a description of the current level of care model are appended. *Technical Monograph no. 82-03. Developmental Disabilities Information Survey.*

**129** *Staff Stress in Care of the Terminally Ill.*
Mary L. Vachon
1979, 5p
**SHR-0009809** Pub. in Quality Review Bulletin v5 n5 p13-17 May 79.

Those who work with the dying frequently suffer considerable stress, and ways of helping them cope need to be developed. Both acute care and hospice settings provide sources of staff stress. Hospital factors include watching patients whom staff have come to know well decline; feeling responsible, guilty, angry, and helpless when the administered treatment fails to forestall death; and losing faith in any treatment effort. Disagreeing on treatment with team members; finding patients and their families burdensome; sympathizing with families' social difficulties; feeling impotent in trying to control symptoms of a patient's illness; and resenting curtailment of treatment for someone cared for over a long period also contribute to hospital stress. Staff conflict is the most frequent expression of stress in hospitals. Hospice staff also experience stress often stemming from disappointment when a "good death" does not occur, frustration in investing energy in caring for people who die, anger at being subjected to above-standard expectations and public scrutiny, and failure to draw realistic limits to what an all-encompassing hospice service can achieve. Staff stress can be decreased by careful staff selection, training, and orientation and by providing well-integrated social support systems both within and without the patient care setting. A total of 11 references are given.

**130** *State and Local AAA's Gear Up for New Contributions Campaign.*
Aging, Washington, DC.
1982, 6p
**SHR-0009815** Pub. in Aging n329/330 p2-7 Jul/Aug 82.

A new nationwide campaign to increase contributions from the elderly for services provided under Title III-B and Title III-C of the Older Americans Act intends to increase the $79 million given by the elderly in 1981 to $120 million in 1983. Services provided include congregate and home-delivered meals, homemaker and chore assistance, legal aid, health screening, home repair, transportation, and information and referral. The Administration on Aging Regional Offices are providing technical assistance to State and Area Agencies on Aging (AAA's) in the fundraising effort. Wide disparity in contribution levels among AAA's suggests campaigns can be strengthened. Examples of active campaigns are found in Pennsylvania, Arizona, and Nevada. Among the strategies used are posters, donation guides to the AAA's, brochures, and bulletins. Important policy procedures for donation drives are to exclude no elderly person from services on the basis of a negative response, to keep all donations confidential, and to use all donated funds within a year. The campaign assumes that older people want to participate in the cost of the programs from which they themselves benefit. Untapped potential is seen in donations for transportation, chore, and home health services. Photographs are provided.

**131** *Strategies for Administrative Reform.*
Gerald E. Caiden and Heinrich Seidentopf
1982, 246p
**SHR-0009717** Available from Lexington Books, D.C. Heath and Company, 2700 North Richard Avenue, Indianapolis, IN 46219.

Public administrators in both the United States and other countries face the dilemma of balancing public demand for services against the limited resources now available to meet that demand. Some strategies seek to reduce expenditures and costs while maintaining public services at their existing levels. They rely on internal structural changes of rationalization and streamlining. They have little direct impact on citizens as recipients of public services, but they do affect civil servants as members of public agencies. Structural strategies seek to raise the productivity of public agencies without increasing costs. They concentrate on structural arrangements, decisionmaking, operating processes, and the professionalization of public agencies. Program strategies act to improve the quality and quantity of public services and the objectives of State activities. They emphasize reduction of State intervention and the regulation and elimination of excessive bureaucracy. The text looks at administrative theory and reform, the need for deinstitutionalization in mental health, and budget reform dilemmas. It discusses approaches to bureaucratic corruption in the Philippines, Malaysia, Indonesia, Thailand, and Singapore; administrative reform in Australia and Bangladesh; and related experiences in the Federal Republic of Germany, France, Israel, the Netherlands, and the United States. The book shows that there are many ways of reforming administrative systems but that the most popular and effective method is changing them from within. Chapter notes, tables, and indexes are given. *Policy Studies Organization Series; General Approaches to Policy Studies.*

**132** *Subcontracting in the Public Sector: The New York State Experience.*
Ronald Donovan and Marsha J. Orr
New York State School of Industrial and Labor Relations, Ithaca. Inst. of Public Employment.
1982, 38p
**SHR-0009721** Available from ILR Publications, New York State School of Industrial and Labor Relations, Cornell University, Ithaca, NY 14853.

This monograph examines the issue of subcontracting as both a legal and a collective bargaining problem in New York State public employment. The experiences of six upstate school districts with subcontracting school transportation services were studied through interviews with school administrators and union representatives. Findings identify anticipated economic savings as the primary motive for subcontracting, along with expectation of greater managerial and technical expertise from the private contractor and removal and labor relations obligations. Older public employees resisted contracting because of threatened pension, health insurance and other benefits, while unions objected to the loss of representation rights and membership. The monograph also considers the private sector treatment of subcontracting disputes. Employees attempting to frustrate managerial efforts to subcontract have resorted to various legal forums, in addition to the customary appeals to labor relations agencies through the grievance procedure. The New York State Public Employment Relations Board's interpretation and application of the Taylor Law to subcontracting disputes and to disputes involving the assignment of unit work to nonunit employees of the same employer are examined. The discussion concerns the nature of the employer's duty to bargain and when that duty ceases. The concluding chapter addresses the development of arbitral standards and the arbitrability of subcontracting grievances. Tabular data and footnotes are given. *Institute of Public Employment Monograph No. 10.*

**133** *Survey Based Needs Assessment: A Paradigm for Planning the Decentralization of Continuing Health Professional Education.*
George E. Fryer and Richard D. Krugman
Colorado Univ Health Sciences Center, Denver.
Health Resources Administration,

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Hyattsville, MD.
1981, 9p
**SHR-0009818** Pub. in Evaluation and Program Planning v4 n3/4 p239-247 1981.

This paper describes the use of a survey to plan for the continuing education aspects of a program, operated in partnership by the University of Colorado and a nonprofit corporation, to remedy the maldistribution of health professionals in rural areas. The survey was sent to all 1,152 physicians and 490 dentists in the program's service area, as well as to a sample of 571 nurses. The instrument was a one-page, five-item questionnaire designed to attain the highest response rate possible. Questions were closed-ended and the cover letter emphasized ease and importance of responding. Responses were received from 58.6 percent of the physicians, 61.6 percent of the dentists, and 39.4 percent of the nurses. Over 98 percent of them believed that their participation in continuing education programs would be beneficial; 61 percent perceived availability of continuing education in their area to be adequate. Nurses identified the most barriers to continuing education access, including travel distance and cost. Of all respondents, 64 percent also expressed the need in their communities for additional professional services in their disciplines in the next 5 years; over two-thirds of them had had no prior contact with the program. The data support the program's primary goal of manpower redistribution by indicating perceived inadequacy in the health manpower supply. The survey was instrumental in effecting continuing education services, subsequently attended in the first 6 months by 1,070 rural health professionals for a total of 8,173 contact hours. Four references and tabular data are given.

**134** *S.W.A.T.: Service Workers Action Team.*
Audrey S. Weiner; Jeffrey R. Solomon and Shayna R. Stein
1982, 7p
**SHR-0009830** Pub. in Aging nos. 329/330 p14-20 Jul/Aug 82.

To meet the health care needs of elderly residents living in Miami, Fla., the Miami Jewish Home and Hospital for the Aged developed SWAT (Service Workers for Action Team). SWAT adopted many aspects of community-based and home health programs in both the United States and England. It included recreational and vocational services as well as social, home health, and homemaker services; it relied strongly on the case management approach to providing services; and it adopted its acronym to create a sense of protection in the residing elderly population. Ten buildings in Miami Beach, housing large numbers of elderly, were initially chosen for a 3-year demonstration project. Data were collected and assessed to determine SWAT's effect. In the 18-month study period, SWAT followed a set schedule announced in advance, so that building residents knew when they were coming. Most of the SWAT clients were widows, with an average age in the mid-70's to upper 70's. Clients averaged from two to four illnesses, but their daily activities were not severely restricted. Those who used the services more were experiencing a decline in their daily living activities. While the data did not show that persons using the program more were doing better after 18 months than those who used the program less, the heavier users did seem to need the program more. Photographs and 17 reference notes are provided.

**135** *Tapping New Resources.*
Carol A. Whitcomb and Maryann K. Miskiewicz
Stanford Research Inst., Menlo Park, CA.
Public Technology, Inc., Washington, DC.
National Association of Counties, Washington, DC.
National Governors' Association, Washington, DC.
1981, 7p
**SHR-0009663** Pub. in Public Welfare v40 n1 p16-22 Winter 1982.

This discussion of nonservice approaches that human service managers have used to deal with declining resources is based on surveys of 37 cities and urban counties. Nonservice approaches are alternative means of sustaining services at less cost. The five types of nonservice methods relevant to the human services manager are (1) regulation or deregulation, (2) changes in tax policy, (3) administrative reform, (4) collaboration with the private sector, and (5) self-help. Greater access for service recipients has been achieved by relaxing zoning and building code requirements for family day care and for group living and other special living arrangements. Tax policy changes have included income tax reductions to neighborhood businesses that concentrate employment and training opportunities on area residents and the receipt of donated services as credits against property tax liabilities. Administrative changes have included the use of school buildings as neighborhood service centers and the development of detailed protocols to tell police patrols when and how to involve social service providers. The use of contributions from the private sector, volunteers, and self-help programs have also enabled local governments to maintain services. Administrators considering such approaches should adapt systems used in other areas to their local circumstances and should involve all affected departments and constituent groups. Photographs and eight references are provided.

**136** *Tax Subsidies for Elderly Care.*
John R. Nelson
Center for the Study of Social Policy, Washington, DC.
Administration on Aging, Washington, DC.
National Conference on Social Welfare, Washington, DC.
2 Apr 82, 21p
**SHR-0009654** Available from National Conference on Social Welfare, 1730 M Street NW, Washington, DC 20036.

This paper describes and evaluates two models for tax subsidies to family-based informal caregiving – the exclusive elderly care subsidy and the general dependent care subsidy. An introduction documents the extensive use of informal family care by elderly people and examines policymakers' renewed interest in informal and community-based care as a less costly alternative to institutionalization. The exclusive elderly tax subsidy offers a deduction or credit to families that care for an elderly relative in their home. The review of this option focuses on bills enacted by Oregon and Idaho and a Federal bill proposed by Representative Tom Corcoran. The general dependent care model is a tax provision subsidizing care costs for any dependents unable to care for themselves. It is embodied in the Federal Child and Disabled Dependent Credit and similar provisions in many States' tax systems. An assessment of both subsidies notes that the exclusive care model is poorly articulated at present and encumbered with burdensome administrative rules. Although the other model is well entrenched in the tax system, it is of limited assistance to a low-income household with little or no tax liability and of no help to families where one of the adults does not work but cares for an elderly relative. The paper suggests ways to improve the dependent care credit and offers guidelines for States on targeting the impact of a subsidy and estimating the costs. Devices used to target the subsidy are discussed in detail, including qualifications attached to recipients of care or the household giving care, definition of care-related expenses, and the nature and amount of the subsidy itself.

**137** *Technology Transfer by State and Local Government.*
Samuel I. Doctors and JoAnn M. Eliason
Pittsburgh Univ., PA. Energy Policy Inst.
1981, 262p
**SHR-0009759** Available from Oelgeschlager, Gunn and Hain, Publishers, Inc., 1278 Massachusetts Avenue, Cambridge, MA 02138.

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These nine essays describe how to promote the transfer and application of modern technology to the operations of State and local governments. They propose policy options to improve the quantity and quality of technology used by these organizations and emphasize the role of the private business sector and the need for the Federal Government to provide incentives for more private sector leadership and involvement. The authors contend that the transfer of innovative technology to State and local governments is necessary and desirable because of the rapid growth and resulting unwieldiness of these governments and because of the growing restrictions on the resources available to support their activities. Many of the requirements of State and local governments can be met by technologies that are already in production. Both the private sector and local government will benefit if they come together to improve local government efficiency and effectiveness. Policy options are presented that (1) promote private sector involvement in technology transfer, (2) take advantage of the flexibility and adaptability of business to deal with the complex and fragmented State and local government market, and (3) concentrate efforts to introduce new technology in areas where resource expenditures are largest and where the greatest savings can be achieved. Tables, figures, chapter notes and reference lists, an index, and 89 annotated references are provided.

**138** *Teenage Pregnancy and Parenthood.*
Carolyn S. Levering and Jeanette Duncket
Association of Junior Leagues, Inc., New York.
1981, 42p
**SHR-0009719** Available from The Association of Junior Leagues, Inc., 825 Third Avenue, New York, NY 10022.

There is a high incidence of unwanted pregnancy among adolescents. Over 1 million teenagers become pregnant each year, resulting in the live birth of more than 600,000 babies. The consequences of teenage pregnancy and parenthood are often grim. Adolescent pregnancy and childbirth pose high health risks, including labor complications, infant mortality, and birth defects. There is also an increased incidence of unfinished education, unskilled employment, welfare dependency, and family instability, which have long-term implications for the young mother, her child, the teenage father, and other family members. The Federal Government has responded to these problems by offering assistance through various programs. The establishment of the Office of Adolescent Pregnancy Programs within the Public Health Service represents a new national policy initiative supporting the pregnant teen and her extended family. Teenagers' increasingly early sexual activity and the prevalence of teenage pregnancy have also focused public attention on a minor's rights to health care. The U.S. Supreme Court has ruled in favor of a minor's rights to abortion and contraceptive services, without parental consent, but the issue is far from settled. With increasing national interest in preserving the family unit, greater attention is being paid to the process of obtaining services for adolescents in need, while maintaining and improving family supports. Each community has a variety of public and private prevention, pregnancy, and parenthood services. Congress advocates, service providers, and community groups are addressing the need to expand and coordinate these programs in an effort to provide effective, comprehensive services for pregnant adolescents and young parents. Footnotes and a list of organizations providing services to or developing resources for adolescent pregnancy and parenthood are included. Author abstract modified. *Occasional Paper no. 1.*

**139** *To Cooperate Or Not To Cooperate: A Report on Intergovernmental Cooperation in Allegheny County.*
Allegheny Conference on Community Development, Pittsburgh, PA.
Pittsburgh Univ., PA. Consortium for Public Administration Field Services.

Apr 82, 98p
**SHR-0009718** Available from Consortium for Public Administration Field Services, 3E15 Forbes Quadrangle, University of Pittsburgh, PA 15260.

This report discusses intergovernmental cooperation in Allegheny County, Pa., and recommends resources to encourage greater cooperation between jurisdictions. Local government budgets in Allegheny County have become financially strained. All municipalities have implemented management innovations, and some have transferred service responsibility to other jurisdictions. The Allegheny County government has received such service transfers over the years, assuming responsibility for such traditional municipal services as public health or providing new services for individual municipalities in mental health, police, and fire training. Moreover, independent authorities have assumed transit and sewage treatment responsibilities. However, since the county government is facing the same fiscal constraints as municipalities, further transfers are not likely to occur without new revenue sources. Recently, councils of government (COG's) have been created to foster cooperation. Eight COG's now exist, covering over two-thirds of the county's municipalities. Although surveys show that citizens approve of cooperation efforts in delivering services and addressing pressing needs, new resources are needed. Governments should establish a coordinating mechanism to compile cooperative opportunities identified by municipalities and have governments, civic agencies, and universities design specific approaches for priority opportunities. Finally, COG's, along with the Allegheny League of Municipalities and the Southwestern Pennsylvania Regional Planning Commission, should provide hands-on assistance to implement specific cooperative arrangements. Graphs, maps, tables, and notes are supplied, and case studies, survey details, and a list of organizations are appended.

**140** *Transcultural Adjustment: An Analysis and Preventive Intervention.*
Jeffrey L. Edleson
Apr 82, 21p
**SHR-0009743** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

This paper uses social learning theory to analyze the transcultural adjustment process and then proposes a social work program for preventing unnecessary emotional distress among immigrants. Each situation confronting an immigrant in a new environment contains three aspects called a learning triad: (1) stimulus events that may represent meanings other than those to which the immigrant is accustomed, (2) responses that may have been appropriate in the previous culture but are no longer so, and (3) consequences that assume differing values in the new culture. Through direct experience with consequences of behavior, the immigrant slowly learns what actions are acceptable in the new culture. However, when new behaviors produce no perceived results, the immigrant may withdraw into an ethnic ghetto. Empirical evidence on life change events suggests that intervention aimed at immigrant populations should be preventive and administered prior to or immediately upon resettlement. One approach would be the culture assimilator technique used with foreign service and Peace Corps personnel to facilitate learning a new cultural environment. All methods are envisioned as taking place in small groups of 6 to 10 immigrants. A total of 23 reference notes are included.

**141** *Uneasy Public - Private Partnerships for Social Services: Massachusetts as a Case-in-Point.*
Aileen F. Hart
22 Feb 82, 20p
**SHR-0009766** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

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In Massachusetts and other States uneasy public-private partnerships for both the funding and delivery of social services have developed. For example, Massachusetts committed itself to deinstitutionalization and to the purchase of services from private agencies during the late 1960's. As a result, many incorporated group care homes came into existence. Currently, the entire group care field – its total funding base – is in jeopardy. The movement in the 1960's, spawned by complementary socioeconomic and legislative forces, also affected free clinics, runaway shelters, and other treatment agencies. Moreover, the growing proportion of voluntary agencies – both established and funded by public monies – has led to an unequal partnership. Because purchase of social services has become the predominant mode for implementing publicly financed services, it can be argued that purchase of service is a partnership. However, interaction of public/private sectors does not constitute an integrated delivery system but is merely a financial reimbursement mechanism. It has not been used as a planning tool or as impetus for an integrative system. Nevertheless, public/private partnerships for planning and integrating the delivery system have developed in Massachusetts. Planners are now facing diminished resources from public, private, and corporate sources; single-issue partnerships between the public and voluntary sectors; and the development of a two-tier system for service delivery in which access to the market is the arbiter of service provision. Endnotes and 15 references are supplied.

**142** *Unemployed Urban Youth and the Private Sector: Why They Need Each Other.*
Brent R. Kimball and Michael R. Sack
Apr 82, 18p
**SHR-0009756** Available from National Conference on Social Welfare, Room 911, 1730 M Street NW, Washington, DC 20036.

Jobs for Youth, a youth employment program in existence for 24 years, helps unemployed youths and young adults with no job skills or training to obtain employment. Jobs for Youth is designed to help young people obtain entry-level jobs without rigid entrance requirements or extensive training programs. It believes that the best education begins on the job. Therefore, it places urban youths into the private sector labor force quickly while supplying supportive, comprehensive counseling and educational services. The ultimate goal is to help clients realize their highest occupational potential. In addition, Jobs for Youth Employer Services canvasses job openings and conducts job placement followup from the perspective of serving the employer. By design, Jobs for Youth seeks out small-sized to medium-sized businesses that offer entry-level training or semiskilled positions, preferably on a full-time basis. The program has demonstrated that the private sector and unemployed young people need and can help each other. Collaboration between the private sector and youth employment programs can result in the establishment of employer advisory boards to bring program staff, employers, and community leaders together for resource and idea sharing and in the creation of in-school programs for potential dropouts as a preventive measure. Two case histories and 27 notes and references are included.

**143** *Utilization of Evaluative Research in Social Welfare Programs.*
William E. Berg and Richard Theado
1981, 10p
**SHR-0009748** Pub. in Social Service Review v55 n2 p183-192 Jun 81.

Data gathered from 12 evaluations of a variety of social welfare programs suggested that there is no relationship between evaluative research techniques and their impact on the program under review. Evaluations should meet certain methodological expectations, but also be held accountable to standards of relevance and utili-

ty. This study hypothesized that evaluations with research methods appropriate to the problem they review will be more likely to be used by decisionmakers than those with inadequate designs and methods. A panel of 6 research specialists reviewed 12 program evaluations completed within a 14-month period by an evaluation and planning agency in a large metropolitan area. The evaluations reflected a wide range of design strategies, although all emphasized process rather than outcome variables. Each reviewer ranked the evaluations according to their use of appropriate research methods. Interviews with program administrators and representatives from the contracting agencies were analyzed to determine the evaluation's impact. The findings failed to support the hypothesis, but did suggest that the evaluation reinforced existing opinions of the program in about half the cases and changed opinions for approximately 28 percent of the respondents. A frequent criticism was that the time between initiating the evaluation and completing the report was too long to allow for an assessment of the program. Four tables and 14 reference notes are provided.

**144** *Vocational Training and Placement of Severely Disabled Persons. Project Employability, Volume 1.*
Paul Wehman and Janet W. Hill
Virginia Commonwealth Univ., Richmond. School of Education.
Virginia Dept. of Rehabilitative Services, Richmond.
1979, 229p
**SHR-0009673** Available from ERIC/EDRS, PO Box 190, Arlington, VA 22210, order number ED-176110.

This volume presents 10 papers dealing with the vocational training and placement of severely disabled persons, particularly mentally retarded persons. A description of Project Employability, a Virginia project designed to promote the entry of severely disabled persons into competitive employment, focuses on the program's rationale, the training model used, and the service delivery model. An analysis of factors that should be considered in helping developmentally disabled individuals enter competitive employment focuses on the client's functioning level and physical characteristics, the client's living situation and transportation needs, client and parent attitudes, and employment's effects on supplemental security income. The employability observation and recording system used in Project Employability is presented along with the charts and forms used in the system. A preemployment training program for moderately to severely retarded adults is described. Case studies of the placement of severely developmentally disabled persons into competitive employment are presented. Discussions of specific skills needed focus on two strategies designed to affect work production, the use of client-administered reinforcement to promote independent work behavior, and the development of job interview skills. Figures, tables, and chapter reference lists are provided. *See also volume 2, SHR-0009672; volume 3, SHR-0009570.*

**145** *Vocational Training and Placement of Severely Disabled Persons. Project Employability, Volume 2.*
Paul Wehman and Mark Hill
Virginia Commonwealth Univ., Richmond. School of Education.
Virginia Dept. of Rehabilitative Services, Richmond.
1980, 198p
**SHR-0009672** Available from ERIC/EDRS, PO Box 190, Arlington, VA 22210, order number ED-195070.

This volume presents 12 papers on the vocational training and placement of severely disabled persons. The papers are based partly on Project Employability, which involves the placement and on-the-job training of severely disabled persons, primarily mentally retarded persons. Emphasis is placed on the perceptions of employers, coworkers, and parents, because

these perceptions are all significant facilitators or inhibitors of job placement and retention. The crucial role of followup after job placement is also emphasized. Specific training techniques are described in conjunction with learning problems that can arise in on-the-job training situations. Methods of advocacy for severely handicapped clients with nonhandicapped coworkers, employers, and parents or guardians are also detailed. A method for assessing the amount of staff time necessary with a client at a job site is presented. An analysis of factors related to unsuccessful job placements focuses on inadequate attendance, excessive tardiness, parental influence and reluctance, vacillation of supervisors regarding such matters as job descriptions, lack of vocational or nonvocational skills, and maladaptive behavior. A case study of an effort to improve the productivity of a mentally retarded woman in a city restaurant and the use of a systematic fading procedure to reduce noncompliance and inappropriate verbal behavior in a moderately retarded food service worker are included. Tables, charts, and references are supplied. *See also volume 1, SHR-0009673; volume 3, SHR-0009570.*

**146** *Walk-in and Telephone Inquiry Service: A Function of a Hospital Social Work Department.*
Barbara Horn; Gaetana M. Manuele and Barbara F. Olvany
1982, 10p
**SHR-0009792** Pub. in Social Work in Health Care v7 n3 p47-56 Spring 1982.

A study of the walk-in and telephone inquiry service provided by the social work department of St. Vincent's Hospital and Medical Center of New York City found that the person most likely to use the service is over 60 years of age, resides within the hospital's catchment area, and has a history of using the hospital. The person most often seeks help for self or a related family member. The study sample consisted of 115 persons who had contacted the department of social work between June 1, 1980, and November 30, 1980. The sample was 55 percent female and 45 percent male. The five most common problems for which persons sought help were the need for financial assistance (health insurance); coping with anxiety, stress, or depression; need for home help; need for outpatient medical or psychiatric care; and problems in interpersonal relationships. The hospital is perceived by the public as a community resource rather than as a narrowly defined medical facility. To maintain effective service quality, the service requires a professionally trained social worker who can use the initial contact to identify the problem rapidly and establish a helping alliance. Moreover, the benefits gained by the hospital, both in its community image and potential use, are substantially greater than the services' cost. Tables and 17 references are included. *Earlier version of this paper was presented on April 2, 1981, at the 16th Annual Meeting of the Society for Hospital Social Work Directors of the American Hospital Association, Philadelphia, Pa.*

**147** *Who's a S/HMO. A Look at Metropolitan Jewish Geriatric Center and Its Plans to Develop a Social/Health Maintenance Organization.*
Dennis L. Kodner
1980, 12p
**SHR-0009708** Pub. in Home Health Care Services Quarterly v2 n4 p57-68 Winter 1981.

This paper presents an overview of the Metropolitan Jewish Geriatric Center (MJGC) in Brooklyn, N.Y., and its plans for a social/health maintenance organization (S/HMO). The S/HMO provides a wide range of health and social services in a coordinated manner to both well and impaired persons over the age of 65. Patterned after the conventional HMO, the S/HMO will serve a voluntarily enrolled population through prepaid capitation. By allowing flexibility in service patterns, placing a cap on program

expenditures, incorporating case management structures, and emphasizing prevention and nonmedical supports, the organization is expected to create an incentive to provide care in the most appropriate and cost-effective setting. MJGC was selected as the first site in a demonstration expected to include two or three other sponsors located across the country. MJGC has developed a large number of community-based resources using the institution as the administrative and delivery "umbrella." These programs include a day hospital, a long-term home health care program, hospice care, and others. The S/HMO will allow MJGC to meet both well and impaired elders' diverse needs in ways that current programs and funding systems do not presently allow. Ten major areas of work at the site are anticipated in the next 12 to 15 months, including formation of the S/HMO corporate entity, approval of HMO status by the State, and organization of the medical group, as well as development of the S/HMO benefit package, the capitation finance plan and system, and integrated case management systems and procedures. A flow chart and reimbursement scheme are provided. *Paper presented at the 109th Annual Meeting of the American Public Health Association in Los Angeles, California, in November 1981.*

**148** *Work in Welfare: Past Failures and Future Strategies.*
Mildred Rein
1982, 19p
**SHR-0009749** Pub. in Social Service Review v56 n2 p211-229 Jun 82.

This discussion of work incentives for welfare recipients covers the failure of the Work Incentive Program (WIN), the work experience and potential of Aid to Families with Dependent Children (AFDC) women, and relevant provisions of the 1981 Omnibus Budget Reconciliation (OBR) Bill. WIN mandated the registration of every appropriate AFDC recipient for work and training and made self-support an explicit goal of social services for AFDC recipients, who were also allowed a 30 and one-third exemption of earned income. These measures did not change the work behavior of AFDC mothers, since the rate at which they work while on welfare has remained at a constant 14 to 16 percent of the caseload. A closer look at AFDC female heads shows that many work irregularly and part-time during the year, but receive low hourly wages and no benefits. The AFDC caseload contains several subgroups with varying degrees of work capacity, and a significant portion exhibit employment potential. However, the trade-off between the benefits of work and the benefits of welfare combined with problems of managing a home and child care produce a rational decision that precludes work. The limited options available to government are reducing welfare benefits, raising wages of existing jobs, supplying better jobs, requiring work, or accepting welfare as a viable alternative to the low-wage job market. The OBR reduces work incentives, imposes work requirements that will result in restrictive State practices, and is unlikely to promote jobs with attractive wages, stability, and benefits for welfare recipients. Because the States have so much leeway under the new law, future practice will depend on their initiatives. A total of 48 footnotes are included.

**149** *Workers With a Handicapping Condition and the Law.*
Frank Thompson
Center for Public Representation, Madison, WI.
Law Enforcement Assistance Administration, Washington, DC.
Wisconsin Council on Criminal Justice, Madison.
Jun 77, 145p
**SHR-0009687** Available from Association for Retarded Citizens, 5522 University Avenue, Madison, WI 53705.

The text explains the Wisconsin Fair Employment Act and the Federal Rehabilitation Act of 1973 (Sections 501, 503, and 504) in terms of who the laws cover, what they require, and how they are enforced (review and complaint procedures). Similarly, it reviews other laws affecting State government employees and applicants (Wisconsin Civil Service Act, Revenue Sharing Act, Wisconsin Executive Order No. 9, and civil actions under the Civil Rights Act of 1871) and looks at laws affecting Federal employees and applicants, such as the Vietnam Era Veteran's Readjustment Act of 1974 and statutes regarding Federal employment and persons with alcoholism or drug abuse records. The guidebook also concerns itself with laws affecting county and local government employees and applicants, including county and municipal affirmative action and nondiscrimination requirements. It explains laws and provisions for handicapped workers, such as affirmative action and nondiscrimination requirements in State contracting, employment licensing, workers' compensation, and union contracts. The text gives practical advice in filing employment discrimination complaints or otherwise attempting to remedy discriminatory practices. The numerous citations specify which laws, statutes, regulations, and other sources contain the original information being explained.

**150** *Young and Marginal: An Overview of Youth Employment.*
Norman Bowers
1979, 15p
**SHR-0009726** Pub. in Monthly Labor Review v102 n10 p4-18 Oct 1979.

The economic literature offers a number of explanations of high youth unemployment, focusing mainly on racial differences – especially among males. Most firms tend to hire older workers, since age is the obvious measure of maturity and stability, and take on younger people only when the demand for labor is high. Young black males and females have higher unemployment rates than their white counterparts; the employment situation for black teenagers may be so bleak as to lead to a permanent situation. The most popular explanation for youth and black unemployment is the post-World War II baby boom, which increased the youth labor pool. This explanation rests on the unproved assumption that labor markets for black and white youth are separated either because of geography or discrimination. Also, the minimum wage may price many less productive young people out of the job market or may restrict the opportunity for young people who work for wages below the minimum to acquire on-the-job training. However, the minimum wage argument does not explain the worsening black-white unemployment differential. Neither racial differences in job-search methods nor increased school enrollment rates are significant indicators. Job suburbanization, skill mismatches, and the influx of women into the labor market also do not explain high black unemployment rates although they have some impact. Tabular and graphic data and endnotes are supplied.

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